

British Medical Practice—Some Recent Innovations

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This presentation might be better labelled "A worm's eye view of the National Health Service" (NHS) as it covers of necessity only a limited spectrum of that program. General practice as a discipline is infinitely variable in its application; and factors of geography, practice size, social classifications of population, and employment patterns can produce enormous differences in the details of practice organization.

My remarks must therefore be very much a personal record of one who has spent his practicing life largely in one town, located in one industrial corner of England. The National Health Service in Great Britain and Northern Ireland came into being on its "vesting day" of July 5, 1948 and any dissertation on general practice in the NHS must include a few words on the situation before that date.

Medical Care Before NHS

The personal doctor was the hub of medical practice. By virtue of several Government insurance schemes authorized by Acts of Parliament from 1911 onward, free medical attention and medicines were available only to insured persons, ie, those gainfully employed for a minimum period of time. Those health services were not extended to their family or dependents, who were covered by various forms of private sickness funds, eg, those run by trade unions, the long established friendly societies, craftsmens' guilds, etc. These latter schemes usually restricted the choice of doctor and the range of prescriptions but provided a captive population for the practitioner. The remainder of the population was private patients paying on an item of service basis and with full freedom of choice of doctor.

The general practitioners usually had access to hospital beds and, if they wished, operative facilities in their local hospitals which were invariably endowed institutions run by voluntary contributions. These hospitals were normally visited on a part time basis by specialists from the larger regional or teaching hospitals. The local practitioners retained total clinical responsibility at all times and used these

specialist services only in a consultative capacity. The general wards of all the hospitals were free to both the insured and the non-insured population and no bed or clinical fees were demanded; however, all trade union branches and local guilds made regular payments toward the upkeep of their local and regional hospitals.

Adequate numbers of private beds were available, and it was from this area that specialists drew their incomes—their services to the general wards and outpatient departments being voluntary. This system had developed slowly over the years, and it must be admitted that it was showing signs of considerable strain in 1942 when the Beveridge Plan appeared on the scene as outlined in the *Report on Social Insurance and Allied Services* prepared by Sir William Beveridge at the behest of the wartime British Government. This report identified "five giants" in the pattern of social progress: "want, disease, ignorance, squalor and idleness." It stated that a comprehensive social security should be introduced through the cooperation of the government and the voluntary efforts of private individuals.

This plan was finally given teeth by the passage of various Acts of Parliament up to 1948, including the National Health Service Act of 1946 which made medical services available to everyone without respect to insured status, age, or any other circumstances. Local executive councils made up of the representatives of the local Health Authority, the Minister of Health and the local Medical, Dental and Pharmaceutical Committees were appointed, and general medical practitioners were made responsible for the provision of personal medical services under contract with the local Executive Councils. Hospital care was planned and supervised through a system of regional Hospital Boards appointed by the Ministry of Health. Day to day administration of the hospital was carried out by hospital management committees appointed by, and responsible to, the regional boards. Preventive, auxiliary and related services in the health field, eg, home nursing and home domestic help, were made the responsibility of the local authorities.

This established the tripartite system of control which is the root cause of many of the ills of NHS medicine. Central finance for the whole system came partly from compulsory National Insurance contributions, and partly from the local authorities and the National Exchequer. The level of payment to the general practitioners in their contract with the Executive Council was negotiated between the Ministry of Health and representatives of the profession, namely the General Medical Services Committee of the British Medical Association. With some misgivings the profession accepted a capitation fee system based on the pattern set by the National Health Insurance Acts of 1911 onwards.

Thus the scene was set on July 5th, 1948. No one, whether politically or professionally oriented, had any idea of what was going to happen or what demands were about to be unleashed. There was indeed on the political side an element of euphoria in the peregrinations into the future.

The profession was in turmoil and its general practice members were still undecided about signing their Executive Council contract even 48 hours before vesting day. The majority finally had to make an undignified rush to jump on the band wagon before it disappeared round the corner; they did this to the accompaniment of much mutual slanging between the joiners and the non-joiners, and many accusations of non-professional conduct. Most of the concern lay in the pricing of the government deal to buy the goodwill of the practices, and the fact that this price tag was only available up to the vesting day—a neat device for making sure that the majority was in at the start!

Short Comings of the NHS Act

For the first two years after July 5, 1948, all seemed much the same except that the number of practices increased as associates in large groups branched out on their own to become principals in their own right. This type of change, along with the fixing of the maximum list per principal at 3,500 patients (1,000 average family groups), effectively mopped up the extra insured patients produced by the NHS Act.

The major unexpected effect of the Act at this point was the difficulty that new entrants to general practice found in gaining a foothold. It was necessary to search far and wide, concentrating on the less favoured parts of the country, for a practice. In fact, choice was virtually limited to the industrial areas, and then the terms for an ultimate equality in partnership shares required 10 to 14 years at levels of $\frac{1}{3}$ to $\frac{2}{5}$ of the partnership profits—thus, in fact, increasing the cost of entry into general practice and leaving the incumbent without a saleable practice at the end of his career.

By July, 1950 practice patterns were much the same as pre-1948, except that the majority of general practitioners were now out of hospital work entirely. Specialists were now appointed full-time to the local hospitals; part-time general practice hospital appointments were being actively discouraged by the regional Hospital Boards, and, in fact, by some local specialists. Only a very few practitioners managed to keep a foot in both camps after 1953, and then only in special local circumstances and with special qualifications. In any case, by this time it was painfully obvious that the general practitioner's work load was increasing, an impression which was confirmed by statistical analysis in my own two-partner practice.

In 1950 the practice consisted of 4,000 patients, each of whom required 1.8 items of service per year; by 1952, 4,300 patients required 2.2 items of service per year; by 1955 the figures were 5,000 and 4.4 services. The increase continued until 1962, when the peak figures of 5,862 patients and 6.2 services per year were recorded—all provided by two general practitioners with two receptionists; you can imagine what this work load represented in terms of hours worked.

During the whole of this period to 1962, there were recurrent crises on the national scene, and disputes with the Ministry of Health on payment were almost continuous. Rumbles of discontent about status, work load, shortcomings of hospital departments, and the iniquities of what almost came to be regarded as the basic adversary, the patient, were almost a daily litany from one's colleagues. These were the symptoms of an underlying malaise caused by the inability of the average conscientious practitioner to do his job effectively. Doctors with full lists of 1,000 family groups found it impossible to do any more than the simplest assessment and treatment processes and, over the years, had to leave more and more to the specialist hospital teams, who potentiated this process by automatically repeating all investigations performed prior to hospital referral or admission.

The basic capitation payment, which contained some provision for practice expense, also contributed to the lowering of general practice working standards—the less money spent on running the practice, the more there was available for the practitioner and his family. There were no means to increase his income except to increase his list of patients, as 95 percent of the population was registered with the NHS. Thus, a premium was laid on inferior standards of practice in a period when there was an increasing work load with consequent increasing stress. In this context, concerned general practitioners had for some years recognized the shortcomings of the service with its increasing pressures, and had begun to postulate ways to change general practice patterns to alleviate these

undesirable features.

As early as 1953, J. S. Collings defined various forms of group practice, and rejected the total and sub-total group practices of the North American model because they diminished the general practitioner's responsibility by dividing it up between consultants. He voted for what he called "Basic Group Practice" which he defined as a ". . . working and financial association of a number of general practitioners sharing the facilities of a small medical center, caring for the whole person, for the family as a unit, providing high level diagnostic and therapeutic service with the aid of organized clerical and nursing assistance" (Collings, 1953). He suggested that the size of the unit should be two to five practitioners serving a population of 5,000 to 12,500. This type of practice should be able to provide personal medical care for up to 90 percent of the needs of the average patient.

By 1964, John Fry was asking, "Will there be a tomorrow in general practice?" and was quoting a World Health Organization Expert Committee as saying that, "The committee is strongly of the opinion that general practitioners fulfill 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" (Fry, 1964). He further said that the loss of the general practitioner would lead to chaos, and instanced as an example the hospital outpatient departments in Sweden. The patients had free access to these, with average outpatient sessions of 100 consultations, thereby swamping the facilities which were misused and wasted without the protective screening of general practitioners.

Pinsent (1950), Crombie and Cross (1957, 1958), and MacDougall (1966) all took this basic group practice a stage further by envisaging graduate nurses with post-graduate training aiding the doctor by assuming full clinical responsibility for certain minor conditions, by acting as a screen in seeing certain categories of patients, and by undertaking selected home visits. Crombie and Cross delegated full responsibility for 16 percent of all episodes of illness in one year to their nurse. MacDougall saw the community nurse as the only practicable solution to the drastic shortage of family doctors, and Connolly (1966) agreed with this view.

Some Solutions to the Early Problems of the NHS

By 1962, a pattern of general practice organization in the NHS began to emerge which appeared to hold some hope of relieving the stress indicated by my personal practice figures previously quoted, ie, 5,862 patients with 6.2 services per year. This pattern may be summarized under five headings:

1. The establishment of a group of about five doctors in a custom built or custom altered central office.
2. The introduction of a full-time appointment system.
3. The provision of adequate clerical and receptionist help.
4. The acquirement and training of a community nurse or "feldsher."
5. The organization of a health team concerned with the provision of all elements of medical and social care for the individual and the family, consisting of the medical and nursing members of the group working in close association with local authority staff, eg, health visitors, home nurses, midwives, children's nurses, medical and psychiatric social workers, and the School Medical Services.

In 1964, another medico-political crisis led to the threat of resignation from the NHS of 75 percent of the general practitioners who were members. This was resolved by a new General Practice Charter which altered the methods of payment in a way which partly removed the disincentive to good general practice which had existed under the simple capitation system. It is in this context, at this time, that my narrative becomes more personal.

I practice in South Shields, County Durham, a town of 108,000 people. It is an amalgamation of industry, port, and coastal resort. It lies on the south bank of the River Tyne in a wedge of land bounded by the North Sea to the east and bridgeless river mouth to the north, and is entered from the south and the west by roads which, of necessity, end in the town. The area measures about $2 \times 2 \times 4$ miles. About half of the population lives within the town, the remainder residing in post-World War II municipal housing estates to the south and west of the "Old Town." The heart of the community has remained in the Old Market Place by the river. The communication and municipal transportation services are excellent.

In April, 1964 after 18 months of planning, negotiating and building, my two-man practice joined with two well-known and well-liked single colleagues, practicing as a group from refurbished and extended premises situated in two three-story terrace houses. These premises were bought by the group and the development costs underwritten by the three senior partners for the first year, and then equally by the four partners from the second year onward. These costs were covered by a ten year group practice loan at commercial interest rates. The practice quarters, confined to the ground floor, consist of an entrance lobby, a waiting room, a reception office with fitted wall shelving for records, four consulting rooms each with a sound proofed examination room, a

laboratory, a doctors' common room, and toilets. Recently the reception area has been extended and a secretary's office added in the laboratory. The upper floors were converted into two self contained apartments for resident secretary-receptionists who provide 24 hour telephone and radio telephone coverage.

In early 1965, we extended a pre-existing limited commitment with the psychiatric department of a local hospital to acceptance of full-time responsibility for all emergency admissions seven days per week, and routine treatments on three days per week. Because of this extra responsibility, we engaged a salaried female partner in October, 1965.

The Use of a Full-time Graduate Nurse

In March, 1965 under the auspices of the Royal College of General Practitioners, we began a study project, financed by the Ministry of Health, to establish how much of the work traditionally performed by the physician could be delegated to a full-time graduate nurse in our partnership of five doctors with 12,600 patients. The objective of the project was to involve her in a limited diagnostic field, in addition to duties of the casualty type, and excluding any form of bedside nursing. She was trained over a period of six months and introduced individually to each of the patients she would be working with by the doctor concerned with the patient's care. She consulted by appointment in her office at the same time as did the physicians, and visited patients in their homes as did they, in her own car. In the office she carried out:

1. Dressings
2. Injections—both therapeutic and immunological
3. The collection of specimens of venous blood, urine, swabs, and Pap smears
4. The preparation and maintenance of the obstetrical kit used in home deliveries
5. The care of instruments and equipment
6. The preparation for, and assistance with, minor surgical procedures

In the field of clinical assessment she was trained to undertake the routine supervision of certain types of cases selected individually by the doctor in clinical charge of the patient, eg:

1. Hypertensive patients controlled on long term therapy
2. Those patients requiring dietary supervision in such conditions as diabetes, obesity, iron deficiency anaemia, and gastro-intestinal disturbances
3. Those patients with stabilized cardiac arrhythmias
4. Those patients stabilized on long term psychotropic drugs, eg, schizophrenia, recurrent and chronic depression, epilepsy, and puerperal psychosis

The nurse obtained the current history, and after reference to the doctor's notes, she made notes of the physical data established after examination. If certain criteria laid down by the doctor in his notes were satisfied, a repeat prescription was provided. If not, the patient was referred back to the doctor as soon as possible, by house telephone if necessary. In any event, the patient was referred back after an interval recorded in the notes, varying from a few days to three months, depending on the condition under treatment. The nurse also attended the daily case conference immediately after morning office hours where she presented her problems and received her home visiting list for the day, after its preparation and discussion.

The nurse made home visits solely in her clinical capacity, attending specific cases at the discretion of the doctor in clinical charge of the patient. Some examples of her work are:

1. Visits to the chronic house-bound sick on long-term treatment
2. Follow-up visits in the case of an established diagnosis, eg, tonsillitis, acute otitis media, and in some infectious diseases and acute febrile illnesses
3. Visits to hospital discharges of all types, but mainly uncomplicated surgical procedures, eg, appendectomy, adenoidectomy, gynaecological cases, fractures, and convalescent medical cases not yet able to attend the office

She was briefed in each case with clinical details and told what to look for, or what information to seek. When reporting back either at the late afternoon office session or the next day's conference, a decision was made as to whether and when a physician's visit was necessary.

During the project all doctor's and nurse's work was classified in two categories: medical or diagnostic and administrative. Each diagnostic category was defined to maintain uniform recording. Each change of activity, from leaving the house to returning to it, was recorded by means of watches screwed to boards in the cars, and by chronostamps in the office. Two runs of one month's recording were taken before arrival of the nurse, and after her training period further recording sessions were taken at intervals over a 12 month period to cover seasonal changes in work loads. During the 12 months of the survey, the nurse worked 33 hours per week in patient contact time, eg, 2½ hours per 1,000 patients. She saw 200 patients per week, doing slightly more work in the office, and absorbed virtually all the work of the minor procedural type. She also contributed to the disposition of patients in follow-up care—especially those with chronic diseases—both in the home and in the office. Statistically, we established that the nurse enabled

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us to save approximately 8 percent of the time we actually worked. The data obtained and the inferences derived from them have been published (Council of Royal College of General Practitioners, 1968).

In mid 1966 it was decided to extend the nurse's clinical role to include primary home visits and primary office consultations. Her home visits were limited to those cases in which a presumptive diagnosis could be made over the telephone, eg:

1. The differential diagnosis of various rashes in both children and adults
2. Upper respiratory tract infections, eg, acute sore throats, acute otitis media, infections, etc.

Initially, she sought a doctor's consultation unless she was presented with a text book case, but experience has, as one would expect, honed her diagnostic ability. In addition, she is occasionally required to make a home visit during office hours to assess the degree of urgency of a call. In her office her primary consultations are limited to those who arrive as "urgent" without having made an appointment. These cases average about three for each morning and afternoon session—but can easily disorganize the physician's appointment schedule if seen by him. The nurse takes a full history of the complaint and undertakes a limited routine physical examination including blood pressure, temperature, pulse, respiration and urinalysis. She records the history and physical findings in the patient's notes, and then reports by house phone to the physician concerned. He then either asks for further information or decides:

1. That the treatment and disposal may be handled over the telephone
2. That the patient should be prepared for a fuller examination which he undertakes in the nurse's consulting room on completion of his current consultation

In the 12 months from January 1st to December 31st, 1967, the nurse saw 529 patients in all categories of care. In the same period in 1968, 808 patients were seen, and in the first eight months of this present year (1969), she has already seen 1,015 patients and has now reached a work load equivalent to the average physician in our group. She has also performed 134 Pap smears since January 1, 1969. In 1968 her effort represented 22.5 percent of the total practice home visits and 13.25 percent of the total office consultations. In 1968 a reduction of physician office consultations resulted in an average increase in consulting time per patient of one minute, raising it to 7.4 minutes per patient. There is no doubt that we are indebted to the nurse for this improvement. This average consulting time represents a range of 2.2* minutes for completing a return insurance note, to

20.8* minutes for a diagnostic history and physical examination. We see our nurse functioning as an essential member of our team—educating our patients in the concept of total family care, carried out not solely by the physician but by him and his team of trained non-medical associates. We have already added four maternity nurses, seconded permanently to our group from the Local Authority Health Department, which is still responsible for their salaries. These nurses help us run our ante-natal sessions and aid us in the few home deliveries that remain. We shortly expect a health visitor seconded from the same source. She will have responsibility for seeking out the medico-social problems of the weaker members of the community and providing supervisory help to the problem families, aided by the home or district nurses who provide bedside nursing in the case of illness in the home. These nurses, too, will serve our patients under our clinical direction. In the future, we hope to have social workers with special training in various fields, eg, geriatric, pediatric and psychiatric, working in close association with us in the office. These people will cover several medical practices of our size, will be on call by us in emergencies, and will cover a regular case load as well.

It is my feeling that we have now reached the limit of the clinical responsibility which a graduate nurse can accept with the present methods of training in the United Kingdom; and, although I realize that some changes will be necessary to adapt this sort of practice in the North American scene, I hope that what I have discussed will give you, as William Shakespeare might have put it, "Much upon to spit and spurn but much upon to think."

Discussion Following Presentation

QUESTION: Were there any difficulties in acceptance of the nurse by the patients?

WOOD: We did expect that this would be a problem; in fact we went out of our way to cover it. We introduced the nurse personally to the patient. In other words, she went in the doctor's car on home visits and was introduced by the doctor to the patient as if she were a medical associate. We followed this procedure two or three times, explaining what she was going to do, and how she would fit into the team. Of course, the majority of patients looked upon this as an extra. They would say, "Oh, now I'm going to have a nurse visiting as well as the doctor," and were a little shocked to find that the doctor was not coming in quite so frequently. These were mainly old folk who had become used to seeing his face every four to six weeks and had saved up a host of questions, which often turned the home visit into a social visit more

* These figures represent the extremes recorded in the initial nurse investigation.

than anything. They looked upon this social aspect as an extra bonus. We had to dissuade them from this, and it did take a little doing. In the six years of this project we have only had one individual patient say, "I will not have this," and this was a psychiatric case who decided that the nurse was responsible for his divorce. Apart from this case I can honestly say that we never had any real problem, which I think is due to the fact that we took the time to get her across to patients. I should say that the major problem we met was the acceptance of our nurse by the Local Health Authority. The Local Health Authority is run by a Medical Officer of Health who employs the whole of this team of non-medical associates. They are very much aware of their position in the medical hierarchy. When we produced this hybrid ancillary who was doing work that even the highly trained health visitors—the most highly qualified auxiliaries in England—were not doing, we expected some objection on their part to our nurse's activities. Being aware of this problem, we were very careful to go along to the Local Health Authority offices and introduce our nurse to each of the individuals with whom she would work in the patient's home, explaining to them where her area of responsibility lay and what we were hoping and trying to do. This, again, was very time consuming, however, in the end, we were quite sure that it was time well spent.

QUESTION: Did other nurses accept this move, or did they say you were diluting the pool of available nurses even more?

WOOD: When we first went into the project, we had the "queen bee" of the nursing association in England on our side. We had discussed the whole problem with her first. The Ministry of Health saw the situation as you must see it, in the context of the strain under which general practice in the NHS was working. There were not enough doctors to go around, and somehow, somewhere, some method had to be found to take some of the load from the physicians remaining in general practice. The Health Department saw the program, I think, as a way to be rid of some of their doctor responsibilities and to take some of the load from the doctors. The nurses themselves were most enthusiastic, and in addition, the nursing press gave us very good coverage. The terms of the remit for the investigation from the Ministry of Health included the need for us to seek our nurse from the pool of unemployed nurses available either in our own practices or, if necessary, outside our practices. She had to be one, who for reasons of domestic commitment, had retired from full-time or part-time nursing some time before. In other words, we were restricted to employing nurses who were not, at that time, employed by any other body. We were unable to find a suitable nurse within our practice population and had to ad-

vertise. There were a very large number of replies; we compiled a short list of six and chose her from amongst these six. In view of this, I think one can say there could be no suggestion that we were diluting the pool of available nurses.

QUESTION: Did you find any difficulty in determining the capacity of the nurse?

WOOD: The whole project developed from the widely held view that there was an area of general practice, mainly with responsibilities of a supervisory nature, which could very easily be done by a less highly trained individual than a fully qualified doctor. It was felt that these areas could be identified fairly precisely, and that with special training, it was within the capacity of a trained State Registered Nurse (with possibly casualty, surgical and medical ward experience) to undertake this supervisory responsibility. By giving this responsibility to the specially trained auxiliary, we hoped that we would have more time to do the assessment and diagnostic processes for which we, the doctors, were trained. I think this is the major point about team medicine—that one hopes to break down the elements in any work process into component parts, the work of each done by people with the right amount of training. One does not want a man who has been trained 9 or 10 years in the extremes of diagnosis to syringe ears or pare toe nails. This is a waste of his time. Each job, or each part of the job, should have an individual trained adequately for that job and that job alone. This, one hopes, would improve efficiency. This is what work-study and operational research is about.

QUESTION: How is she compensated?

WOOD: If we are speaking of financial compensation—one of her many compensations—she is paid what a graduate sister of five years experience in a hospital ward would be paid. We look upon her as our ward sister, collecting information and feeding it back to us. This is the way we arranged her rating, and she is paid around \$3,000 per year. In addition, she gets superannuation benefits and the usual sort of holidays with pay. She has her own car, and we pay some of her car expenses. Apart from that, the contact with the doctors on a personal basis is what she finds to be the most tremendous compensation.

QUESTION: Is she paid by the System or by you?

WOOD: She is paid by us, by our own practice. We are then reimbursed by the System for a proportion of this, but the ceiling of this reimbursement is \$1,680 per year and we get about 65 percent of that. Above this amount we receive a diminishing reimbursement which comes out of our practice expenses.

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QUESTION: How does the nurse's income compare to the doctor's?

WOOD: The average general practitioner with the average list in the United Kingdom is paid at a level fixed by the Government (the Health Department in discussion with the General Medical Services Council) at about \$10,000 per year, after he has paid his practice expenses. This is an arbitrary figure because practice expenses vary tremendously as, of course, do practice incomes. Our expenses, for instance, are about 10 to 15 percent higher than the average for the whole country, because we run this sort of operation.

QUESTION: I emigrated to the United States from the United Kingdom some years ago. Does the system of direction to a practice by the Executive Council still pertain?

WOOD: There is no control of that sort nowadays; in fact, I do not really remember this ever existing. To refresh your memory, the system is such that the Executive Council will advertise a practice vacancy; doctors will apply for this vacancy, and their applications are assessed by the Medical Practices Committee of this Executive Council. This committee consists usually of four to five people—two doctors, two lay members, and usually one medical chairman. They interview the candidates on the short list and decide which of them should practice in the particular area, bearing in mind the type of area and the type of candidate required. I think that you will recall that in your time there were probably 300 to 400 applications for each practice vacancy. These days have now gone. There are practices at the moment in England for which there have been no applications at all, and they need be re-advertised time and time again. The good practices in the nicer part of the country might have five or six applicants. The reason for this drop in number is simply that the G.P.'s have disappeared from the scene. Like you, my friend, the good ones have left.

QUESTION: How long does it take to get a chronic case into a hospital? Is there still a two to three year waiting time?

WOOD: Simply, no. In my area I have no difficulty at all. We have a very efficient geriatrician who has organized his unit on a flow basis. He invariably has one emergency bed available for either sex. This he holds as an absolute minimum, and my colleagues and I have no real problems in getting geriatric patients into the hospital. Sometimes the psycho-geriatric cases can be a problem. I think those of you in general practice will know what I mean by this. When they are very disturbed and obviously must go into hospital accommodation, it is then often extremely difficult to get them out again. Though there is quite a large unit in our area, we never seem to

have enough beds for the psycho-geriatric patients. I think one of the reasons for this is that we are able to keep them alive so much longer now than in the past. We do not have anything like a two or three year waiting list. In an acute case it might possibly take two or three days; in an absolute emergency, I would not have to wait at all.

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