School of Health and Related Research (ScHARR)
University of Sheffield

Speaking for a change:
An oral history of general practice

Graham Smith
with Rona Ferguson, Elizabeth Mitchell,
Malcolm Nicolson, and Graham C.M. Watt


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- supports statutory health bodies overseas and has partnership arrangements with the far east, and with other leading universities and institutions in Europe.

Professor Ron Akehurst
Dean of the School of Health & Related Research
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Preface

David Hannay

'So you want me before I’m away.’ He was dead right, because I had been tape recording old people for a local history for some time, and most were now dead voices from the past. Jock was one of the last who had lived in the village all his life. There were 80 children in the local school when he started there before the First World War, but only 12 when it closed in 1964. Where had all the children gone and what stories could be told by ruined cottages and refurbished second homes? Then there was plenty of work in farming, forestry, fishing, and quarrying. Now machines have taken over manual work, few fish have been left by commercial trawling, and the last granite quarry was closed to balance the books of a multinational. Yet over 150 former pupils attended a millennium reunion and they came from all over the world.

Those whose lives spanned the 20th century have seen more changes in their lifetime than at any other period of human history — from horses and carts to men on the moon. Nowhere is this more true than for general practice — a complex craft of personal caring tossed on the stormy seas of politics and driven by the winds of new technology. Technical change invariably precedes social change, and to understand this we need information from those who were part of the process. Tape recorders and qualitative methods have made this possible. Three times I have made attempts at writing a practice history. The first attempt failed because I moved jobs after interviewing a retired senior partner about the advent of the NHS. During the second attempt, a lifetime’s recording of house visits by a single-handed rural GP were thrown out by his family when he died, and the third time over 30 years of practice mortality were lost when moving premises. But there have been some higher degrees in practice history, and this series on the oral history of general practitioners in Paisley is a welcome addition to our knowledge.

But is oral history ‘research’— which literally means ‘looking again at’— let alone scientific research? The answer is a qualified ‘yes’, the proviso being that the data should be put in a theoretical context. It is this which distinguishes qualitative research from journalism. Tape recordings of oral history give us primary data in contrast to the secondary data of historical research. Science is not just the collection of data but an attempt to make sense of the world with explanatory theories, which according to Karl Popper\(^1\) must be capable of being disproved. In the physical sciences we can control and experiment, so that theories are deductive and predict. In the social sciences we have much less control and proceed by induction with theories which describe but are usually poor predictors. These theories may be broad ranging, such as those of Talcott Parsons\(^2\) on social structure and Karl Marx\(^3\) on class conflict, or they may be less ambitious middle range theories as described by Robert Merton.\(^4\) But always there is the subjectivity of the observers and our own frame of reference as emphasised by Anthony Giddens,\(^5\) and reflected in the postmodern approach of deconstructing reality.\(^6\)

Oral history should help us develop middle-range theories which explain what is happening and give us insights into the process of change. For instance, what are the forces which shape new conditions for general practitioners, from those of Lloyd George and the advent of the NHS to the 1966 charter and the 1990 contract? What

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social pressures are behind the present new contract with its increasing complexity and accountability? What is the balance between control and trust, between professional relationships and impersonal monitoring? Although international comparisons help, we cannot easily experiment with social change, but have to wait upon events. These take place over time, that great mystery which we cannot control — especially when we are part of the experiment ourselves.

**Author’s note and acknowledgements**

‘Speaking for a change’ was first published as a series of monthly articles in the *British Journal of General Practice* between June 2002 and May 2003. In this collected version of the series some minor editorial changes have been made. The biggest differences, however, is the re-integration of the oral evidence and the historical interpretation. In the monthly series the history was followed by the evidence — a layout made at the suggestion of the Journal’s editors. This worked less well with collation of the 12 pieces, hence the reintegration.

First of all I would like to thank all those who assisted with the study and especially those who gave their time and energy to be interviewed. I would also like to thank the transcribers including Shirley Allardyce, Rae Mc Bain, Christine Fitzpatrick, Karen Kane, and Nicola Watson.

Without the funding provided by The Wellcome Trust, under the Trust’s History of Medicine programme, the study would never have taken place.

The support of the Alec Logan, the deputy editor of the British Journal of General Practice was crucial in creating the series, as was the informative comments of those who refereed the articles. And many thanks to my fellow contributors, Dr Rona Ferguson, Dr Elizabeth Mitchell, Dr Malcolm Nicolson, Professor Graham C.M. Watt, and Professor David Hannay for the preface.

The photographs that have been added to this collected version of the series are either reproduced under a Creative Commons agreement (including Sarah Quinn Armit, Bob the courier, ibroadfo, Echosnare, Scott Foy, milknosugar, Muffet, Myrrien, T*'+K, timtak, titanium-white and WMUD) or with the express permission of the photographers (including Annierib and Dazzababes). The photographers’ work can be found on the Flickr website with the exception of Nicky McKenzie who is a member of the Paisley Photographic Society and Robb.
1. Setting, methods and analysis

Graham Smith, Malcolm Nicolson, and Graham C. M. Watt

Introduction

Peter V: There are always challenges. Change is always taking place. You are really trying to find the best change that is taking place and make sure you are taking advantage of that for the good of your patients and your own practice.7

Brian R: The job’s not as satisfying at present... No... Because I don’t know what the future’s going to be for general practice … The doctor is away down in the pecking order and ignored … I think we’re devalued and I don’t know what the future holds for us.

…So what would make a big difference?

Brian R: What would make a big difference? [Pause] Ehem [pause] being listened to …8

While there have been several social and political histories of general practice describing the extent of the reform under the National Health Service (NHS),9 the impact of change on the work and lives of rank-and-file GPs has tended to be hidden from history. In this introduction we present the methods we employed in our systematic study of the recent history of general practice in a Scottish town.

Setting and data collection

The town of Paisley in west central Scotland is near Glasgow but regards itself as distinctively different in character. Its population of approximately 85,000 people is typical of the West of Scotland, in sharing the problems of deprivation and the associated increased morbidity and mortality. Paisley is compact enough for personal contacts to make a meaningful difference, but large enough to yield a considerable amount of information, much of which is relevant to other centres.

At the time of the study the town had 13 group general practices with patient list sizes close to the national average. Paisley does not have a teaching hospital and in addition to the local Royal Alexandra Hospital onward referral of patients is made to Glasgow, which also contributes to the continuing education for the town’s GPs.

Between 1999 and 2001 life history interviews were recorded with seven retired and 24 working GPs. Testimonies were gathered from at least one partner in each of the practices currently functioning in Paisley and also from three practices that no longer exist. Copyright permission and written consent to make use of the oral histories were obtained from each of the interview partners in compliance with the guidelines of the Oral History Society.10 Interview partners were also asked whether they wished to be identified or whether their evidence should be anonymized.

The project was introduced to GPs at a Local Health Care Co-operative (LHCC) meeting for Paisley GPs at which all the practices were represented. Practitioners were asked either to volunteer themselves or to suggest others who might be interviewed. Initial contacts were interviewed and asked to suggest other potential interviewees. We included in our list of contacts GPs whom it was suggested should not be interviewed. As the study proceeded there were practitioners who

7 From General Practice in Paisley (GPP) project interview number 01.
8 From GPP interview number 05.
10 Ward A. Copyright, ethics and oral history. Colchester: Oral History Society; 1995. These guidelines have subsequently been updated and can be found at http://www.ohs.org.uk/ethics/index.php
volunteered themselves for interview and were added to our list of contacts. No one refused to be interviewed. We requested interviews with eight of the 23 GPs who qualified in the 1980s, 11 of the 19 who registered in the 1970s, and five GPs who entered practice in the 1950s and 1960s. We also interviewed a further eight of the 10 retired doctors who were identified as contacts. This strategy enabled comparison between the ways in which members of these different cohorts recalled their careers.

The enthusiasm displayed by most participants generated on average over three hours of recordings. The system of recommendations we used to identify potential interview partners encouraged participation and can in part account for the lack of refusals, but cannot completely explain the level of cooperation we received. Not only did the GPs enjoy talking about themselves and their work, but they also believed that they were contributing to a much larger project. A number of the GPs who were interviewed articulated the belief that there was a lack of understanding of everyday practice amongst policy makers. Through the oral history interviews it was hoped that the voices of rank-and-file practitioners would be listened to in a way that would inform both colleagues and others about individual and collective experiences of practice.

Two GPs, who were in partnership, insisted on being interviewed together, but the rest of the interviews were carried out on a one-to-one basis. Most of the interviews were conducted over several sessions and in a location of the practitioner’s choice. In an initial interview session the participants were encouraged to recall their lives, including their careers, and to identify events and influences that they believed were significant in shaping their life stories. After these open-ended life history interviews, 25 GPs agreed to at least one additional session in which more specific questions were put from a developing interview schedule. All of the interviews included accounts of the reasons and motives that GPs gave for their entry into practice and details of their education and training prior to becoming partners. Interviewees also provided further detailed information about family, career and practice histories.

Table 1: Percentage of size of partnerships by numbers of Unrestricted Principals & Equivalents (UPEs) in England, Scotland and Paisley in 1999

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th>Scotland</th>
<th>Paisley (and of those interviewed)</th>
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</thead>
<tbody>
<tr>
<td><strong>Small</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 3 UPEs</td>
<td>36.02</td>
<td>31.20</td>
<td>23.64 (32.00)</td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 and 5 UPEs</td>
<td>33.14</td>
<td>36.12</td>
<td>30.91 (32.00)</td>
</tr>
<tr>
<td><strong>Large</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 or more UPEs</td>
<td>30.84</td>
<td>32.68</td>
<td>45.45 (36.00)</td>
</tr>
</tbody>
</table>

**Study participants**

Paisley’s GPs have traditionally attended a narrow range of secondary schools in Glasgow and most are graduates of the University of Glasgow. In 1999, 50 out of the 54 working GPs in the town graduated from Glasgow. Three of the four who graduated elsewhere were interviewed for the study. These ‘incomers’ provide valuable perspectives on both Paisley and Glasgow medical networks and in doing so suggest that the Glasgow graduates tend to take local and regional networks for granted and operate within them as a matter of routine.

The profile of general practice in Paisley differed in a number of respects from that of elsewhere. For example, there were no single-handed practices in the town when the study started in 1999, whereas around a tenth of practices in England and around a twentieth of practices across Scotland were single-handed in 1999 (see table 1). Paisley also had a greater proportion of practices with six partners or more than in either England or Scotland.

Fifteen out of the 24 working GPs we interviewed had passed their RCGP membership exam. Given that around a third of principals in England and Scotland were members of the College in 1999, this suggests a significant bias. And yet in 1999 31 out of the 54 practicing GPs in Paisley had passed the exam, while 26 were paid-up members, and two were Fellows (both of whom we interviewed). The higher than average numbers of College members in Paisley was to some extent therefore reflected in our study.

Women are also under-represented in the study, especially younger women. Whereas just over a third of working GPs in Paisley were female, a quarter of working GPs interviewed were women (see table 2). In part this is a result of the late entry of women into the profession and our decision not to interview GPs who had qualified since 1990.

**Data Analysis**

Several analytical approaches were taken, including considerations of how the oral evidence was expressed both in terms of the language used, in the ways life stories were presented, and in the importance of subjectivity, especially the relationship between individual and social historical consciousness. Our narrative analysis suggests a significant bias. And yet in 1999 31 out of the 54 practicing GPs in Paisley had passed the exam, while 26 were paid-up members, and two were Fellows (both of whom we interviewed). The higher than average numbers of College members in Paisley was to some extent therefore reflected in our study.

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**Table 2: GPs interviewed and Paisley GPs by gender and activity**

<table>
<thead>
<tr>
<th></th>
<th>Working GPs Interviewed</th>
<th>Retired GPs Interviewed</th>
<th>Numbers of GPs practicing in Paisley in 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>18</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>6</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24</td>
<td>7</td>
<td>54</td>
</tr>
</tbody>
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Source: Argyll and Clyde NHS Board see [http://www.show.scot.nhs.uk/achb/](http://www.show.scot.nhs.uk/achb/)

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was underpinned by the constant comparative method, derived from grounded theory, requiring a cyclical process of induction, deduction and verification. This process began during the collection of the interviews when we aimed to reach what might be described as a saturation of knowledge in which further recordings of life stories confirmed what we had already understood. Thus we reached points at which the testimonies we were collecting were confirming the findings we had reached from the testimonies we had already collected. Assisted by the use of QSR NVivo© software, ideas were tested and evidence shaped as the study proceeded. Such a strategy allowed for the ongoing comparison of the testimonies of different GPs and was valuable in understanding the ways in which GPs narrated the history of partnership and how partners practiced medicine, including informal specialization.

A number of the GPs commented on the broad open-ended questioning employed in the first session. It was not only different from the more focused history taking that they were used to, but concerns were also expressed about the relevance of the evidence being collected. The interviewer, an experienced oral historian and a non-clinician, was able to address these anxieties and at least two-thirds of the recordings contain enough information to facilitate an understanding of the reasons why individual interviewees choose the stories they tell to illustrate their reflective life histories.

This process of making meaning, and thus determining content, was not only shaped by the GPs’ efforts to meet what they perceived to be the needs of the interviewer or project, but also by their attempts to present coherent life histories, their understanding of the history of their profession, and by the ways in which current events shape the way that the past is interpreted. In analyzing the recorded interviews these variations of emphases was taken into consideration. We would argue that by examining inter-subjectivity, memory and the construction of narrative in this way we can better understand the past from a range of viewpoints. And it is these perspectives that are explored further in the following.


In my interviews with Paisley’s general practitioners (GPs), the doctors regardless of their age reported that their parents had influenced their choice of medicine as a career. However these parental influences were exerted in different ways that were often related to the social backgrounds of the GPs’ families of origin. And the there were other factors shaping the subsequent choice of general practice as a career. Most notably changes in the status of general practice over the last fifty years – changes that meant that the attractiveness of general practice waxed and waned over that time.

The family emerges as particularly significant in initial decisions that led to the study of medicine. Earlier research suggesting that fathers positively shaped the medical careers of their children was confirmed in our study. The retired GP Douglas H, for example, recalled:

All my life I have been led in the direction of medicine. My father would have liked to have been a doctor; he was in the RAMC in the First World War. When I finished school in 1943 I had a notion to join the Indian army. My father told me not to be a fool, I’d be much more use to humanity with a medical degree... As it happened I got my war later anyway... And similarly a large proportion of general practitioners (GPs) had fathers in the ‘higher professions’, including medicine [9], science [2] and religion [2]. This included David R., who entered practice in the early 1980s.

There’s always this implicit encouragement of example and it seemed to me that he [his father, who was a consultant radiologist] had a fairly comfortable lifestyle. Our family never had to worry about unemployment… that I only realize now is such a huge feature of other people’s lives.

And it was the authority of these fathers that was recalled as influential in deciding how and where their young would be educated.

Eleanor H: And my mother was definitely subservient. It was his [father’s] authority that held within the house. He guided me into the scientific school career. I was good at languages at school and he told me that I was to stop French and Latin and do German, cause he reckoned that German was the language of science and I still remember that phrase (laughs). … I think he was quite proud that I did medicine [qualifying in 1974].

While some fathers encouraged entry into medical schools, there were others who tried to deter their children, especially daughters, from studying medicine. Such attempts at dissuasion could however galvanise rather than diminish ambitions.

Gerlind H: I don’t think my dad [who was a GP] was particularly keen for me to do medicine – well he said he said he wasn’t. … I don’t think that he was particularly fond of doctors … and I could see his point when I came to university [in the 1980s] there were an awful lot of tossers that did medicine … We were kind of I’d say slightly apart from the large majority of the Hutchie [Hutchesons’ Grammar School], Glasgow Academy, Glasgow High, Notre Dame type people. I don’t know what school you went to, but I hope I’m not offending you?

Similarly Fiona T., who qualified in 1981, recalled:

I always wanted to be a doctor from primary school age and that was it. …My dad was a general practitioner. But... I wouldn’t say I was particularly encouraged to go into medicine. …My father was very much that I shouldn’t do this. Educating women was a

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14 Twenty-six out of 31 of the interviewed practitioners provided details of family histories when recalling their reasons for choosing careers in medicine.


16 From GPP interview number 16.

17 From GPP interview number 06.

18 From GPP interview number 12.

19 From GPP interview number 31.
waste of time. It was going to cost a fortune and I would get married and throw it all away. I can remember a terrible fight about this. ... I held off from having children for a long time ... and it came to the stage where my father was getting angry at me for not giving him grandchildren (laughs). And I felt like saying, "Well make your mind up. Do you want me to be a doctor or do you want me to be a wife and mother? And why should I do what you want me to do anyway?" 

For those doctors who originated in families in which parents were employed in lower middle and working class occupations the role of fathers in career decisions was less pronounced. Amongst these GPs the importance of schoolteachers and school friends was more likely to be stressed.

Linda F's father was a welder and her mother worked as a lathe operator before taking part-time cleaning jobs. Unusually for someone from her background, Linda, in the early 1970s, attended a fee-paying, single-sex, school in Glasgow.

My [school] friend's parents were doctors and I'm sure that's where it came from. I was back and forwards to their house all the time. Her eldest sister did dentistry and her brother did medicine, so it was all medicine talk.

Others of a similar age and background, like Colin R, were encouraged by schoolteachers to consider medicine as a career.

[I] had no great ambition to be a doctor. But when I went to the careers master he said, "Well, you've got a good group of Highers and you're not brilliant at anything, but you're ok across the board". And he would suggest medicine or law, and I didn't fancy law - stupid me (laughs).

But it is the influence of mothers that tended to be recalled by those GPs who had been raised in less privileged circumstances. For example, John H's mother worked in a variety of part-time office jobs and his father was a joiner with Glasgow Corporation.

Mum is quite a sort of driving force. I think she decided I was going to be a doctor when I was a baby and I've resisted that right the way through until I actually had to fill in my form for university. ... Both of my parents have had a lot of influence in my life. My dad's a fairly placid guy with a wicked sense of humour and my mum's got quite a bit of drive. It was really my mum who I think got the family where it is today. I think they look on it as a big achievement to have two kids who are doctors, having come from a pretty poor background.

Many years later some continue to keep their mothers in mind.

Colin R: I think ... if this was my mother what would I want her doctor to do for her? And if it's good enough for my mother then it's good enough for your mother.

While the influences surrounding application to medical school have altered little since the Second World War, the motives for entering general practice have changed much more during the same period. So, when older retired family doctors spoke about joining their first practices their narratives were marked by a lack of autonomy. For example, Hector M's account of 'falling' into general practice was rather typical of stories told by other members of his generation. During the Second World War Hector was a senior house surgeon in the Royal Alexander Infirmary. At the beginning of July 1944 he was still expecting to be conscripted into the armed services.

But I was told by the War Medical Committee that I would have to do some time in general practice. They were short of GPs and had plenty in the army at that time, so I was offered the choice of going to Caithness, Stornoway and somewhere equally outlandish or to Doctor Barr, 15 King Street, Paisley.

20 From GPP interview number 28.
21 From GPP interview number 18.
22 From GPP interview number 22.
23 From GPP interview number 21.
24 From GPP interview number 22.
25 From GPP interview number 13.
Six years later Douglas H was serving as a Regimental Medical Officer in Korea, which he described as, ‘Just general practice, but in a rougher circumstance’. On leaving the army he found that,

*Beggars couldn’t be choosers … jobs were not hanging on trees… The last place I wanted to work was Paisley, because my father was a minister in the town and it’s not always a good thing. I could have been labelled just his son and not developed an identity of my own.*

By the 1960s there were growing generational differences between older doctors who had entered general practice by chance and increasing numbers of younger doctors who had entered the profession as a matter of choice. That joining the profession is recalled along such distinct lines could be seen as evidence, at least in part, of the outcomes of improving conditions and the subsequent rise in morale that flowed from the Family Doctor Charter and the resultant improved general practice contract of 1966.

With these changes in the profession, the attitudes of entrants were changing too, even if others were holding fast to their preconceptions.

*Robert B: I never saw general practice as being a place for failed surgeons or physicians, never … [However] the new hospital consultants in Glasgow without question … [would say], “Oh, you’re just a GP”.*

The narrated career histories of members of the younger cohort were less fatalistic than those offered by retired family doctors. And there were also subtle differences between the ways different younger GPs talked about their choice of profession. The doctors who qualified in the late 1960s and afterwards would often discuss their unsuitability for careers in hospital medicine. Some believed that they lacked the social capital to participate in a system of patronage. But in the interviews they also expressed many more criticisms of secondary care than their older colleagues made. Most of the younger GPs concluded that medicine in the community offered a freedom from the hierarchies and regimes of hospital medicine.

*Andrew K: I had my fellowship [from Edinburgh] and I had to decide what I was going to do … I applied for a post, a step up, in urology, which I didn’t get because there was a lot of applicants… I [had] said to my wife at the time, “If I don’t get this post I am going to go into general practice”. That was really the decision. Looking back on it part of this was I don’t want to bend at the knee. I don’t like this hospital set up.*

In contrast, those who became GPs in the 1980s were much more likely to claim that general practice was their first choice.

*Linda F: It was weird. I just suddenly thought, “No, I don’t think I really quite fancy this.” I could see all the backbiting and the backstabbing … You also saw how people used their contacts, their own personal family contacts in working out jobs and stuff like that. I realized I didn’t actually have any of these footholds… But having said that, general practice was the primary choice.*

And amongst those who entered the profession at this time, there were those who claimed that community based medicine was the only medicine that they had ever wanted to practice. Along with other younger doctors, they stressed the promises that a career in general practice seemed to offer.

*Christopher J: I’ve always had GP stamped on my bum … I’m independent minded and bloody minded and I hate being told what to do. I got the impression that in general practice you could really rule your own life.*

Change in general practice has also transformed the impact of practice on the family lives of doctors. In earlier times, especially before the 1960s, many GPs had depended on wives to act as receptionists.

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26 From GPP interview number 16.
27 From GPP interview number 23.
28 From GPP interview number 25.
29 From GPP interview number 18.
30 From GPP interview number 02.
and even as nurses.\textsuperscript{31} Practice premises, the introduction of practice receptionists, appointment systems and more recently out-of-hours services have meant a separation between home and work. General practice has become an important choice for those wanting a family friendly option. Eleanor H, who qualified in the mid-1970s, recalled that, 

*My original reasons were that I wanted to do something that definitely involved patient contact. And I wanted a job where I would be using my medical diagnostic [pause]* 

\textsuperscript{31} A variation on this pattern was reported by Margaret G (GPP 24). She was reliant on her mother who would answer the telephone at night.

skills. I was engaged and I knew that I wanted to get married and wanted to have a family in due course. So, I want the kind of job where I can take a part-time commitment and at that stage there were no sort of part time medical jobs whatsoever.\textsuperscript{32} 

Peter V’s first child was born in 1980, ‘two years before going to general practice’. 

*I think when you’re married - first of all it shapes your career. And then your mobility is severely limited by having children. If I hadn’t been married and I hadn’t had children my career would probably have been quite different. To take a research registrar’s job was severely crippling financially and certainly one person can survive well, but not a family, you couldn’t live on it, no.*\textsuperscript{33}

In conclusion, the broad influences leading to entry into medicine changed very little between 1940 and 1990 according to the practitioners who were interviewed. While the mix of entrants remained the same in respect to their social origins, there were changes in the gender composition of entrants. Medicine arranged along authoritarian and hierarchical lines was particularly alien to those who were raised in working and lower middle class households, as well as to female entrants more generally.

There much clearer evidence of significant changes in the ways the Paisley doctors talk about entry into general practice. A period of low morale in practice, similar to today’s crisis, was ended by an improvement in material conditions and future prospects. In the 1970s and 1980s general practice became a positive choice for many, a situation that would improve primary care’s ability to play an effective and leading part in the delivery of health services.

\textsuperscript{32} From GPP interview number 12. 

\textsuperscript{33} From GPP interview number 01.
## Table of origins

<table>
<thead>
<tr>
<th>Number</th>
<th>Gender</th>
<th>Generation</th>
<th>Father's Occupation</th>
<th>Mother's Occupation</th>
<th>Number of Siblings</th>
<th>Attended private (Secondary) school?</th>
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<td>GPP 01</td>
<td>m</td>
<td>C</td>
<td>Teacher (army then schools)</td>
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<td>3</td>
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<td>GPP 02</td>
<td>m</td>
<td>C</td>
<td>Pathologist</td>
<td>Physiotherapist</td>
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<td>GPP 03</td>
<td>m</td>
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<td>GPP 04</td>
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<td>D</td>
<td>Headmaster</td>
<td>Deputy head teacher</td>
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<td>GPP 05</td>
<td>m</td>
<td>D</td>
<td>Metallurgist (Civil Service)</td>
<td>Housewife</td>
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<td>GPP 06</td>
<td>m</td>
<td>C</td>
<td>Radiologist</td>
<td>Housewife - voluntary work Red Cross</td>
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<td>GPP 07</td>
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<td>B</td>
<td>Accountant (railway)</td>
<td>Mill worker</td>
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<td>GPP 08</td>
<td>f</td>
<td>B</td>
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<td>Nurse</td>
<td>6</td>
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<td>GPP 09</td>
<td>m</td>
<td>C</td>
<td>Minister (Church of Scotland)</td>
<td>Housewife</td>
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<td>GPP 10</td>
<td>m</td>
<td>B</td>
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<td>Nurse</td>
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<td>GPP 12</td>
<td>f</td>
<td>B</td>
<td>Industrial chemist</td>
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<td>GPP 13</td>
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<td>A</td>
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<td>GPP 15</td>
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<td>Draper (own business)</td>
<td>Clerkess, then housewife</td>
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<td>m</td>
<td>B</td>
<td>Missionary/minister Church of Scotland</td>
<td>Housewife (minister’s wife)</td>
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<td>B</td>
<td>GP, then in RMS</td>
<td>Doctor’s wife</td>
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<td>GPP 18</td>
<td>f</td>
<td>C</td>
<td>Welder</td>
<td>Lathe operator, and then housewife and part-time cleaner after marriage</td>
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<td>B</td>
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<td>GPP 21</td>
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<td>C</td>
<td>Joiner (Council)</td>
<td>Various (clerkess, bar work)</td>
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<td>GPP 23</td>
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<td>B</td>
<td>Policeman and then hill farmer</td>
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<td>GPP 29</td>
<td>f</td>
<td>B</td>
<td>Pathologist</td>
<td>Secretary prior to marriage. Housewife after</td>
<td>1</td>
<td>Yes</td>
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<tr>
<td>GPP 31</td>
<td>f</td>
<td>C</td>
<td>GP</td>
<td>Nurse, then housewife (doctor’s wife)</td>
<td>5</td>
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GPP 11 withdrew from project
GPP 14 (a and b) was a group interview with two partners in the same practice.
GPP 26 is an interview with a general physician, born 1917, who worked at the local hospital. Details are missing for five out of the 30 GPs interviewed (GPP 14a, GPP 14b, GPP 24, GPP 27, and GPP 30)

A Retired (began in practice prior to 1948); B Retired and older working (21+ years in practice)
C Mid career (11-20 years in practice); D More recently in practice to mid career

m male f female
3. Partnerships
Graham Smith

As I listened to Paisley’s GPs talking about their practice partners I began to recognise the existence of practice-centered oral traditions that chart developments that included the changing pressures on partnerships. Before discussing these oral traditions in more detail, I want to make some general points about the history of partnerships.

In the second half of the 20th century, general practice experienced a long-term decline in the numbers of single-handed doctors and an increase in group partnerships, with the Family Doctor Charter accelerating ‘the decline of single-handed practice’. The new fees and payments introduced after the mid-1960s improved conditions, especially for new entrants to general practice whose exploitation prior to the Charter was so often recalled by older GPs. Change after 1966 included the introduction of the group practice allowance that encouraged the emergence ‘of larger partnerships of five, six and more doctors’,

Most GPs talked about their early years in practice as apprenticeships. This even included those doctors who entered practice after the 1960s and joined partnerships in which assistantships and working to parity had all but been abandoned. Looking back after many years of experience as a trainer, Gerard D, for example, recalls the role his partners had played in making him the doctor he is today.

I spent a fair bit of time asking and talking to partners at that time [the early 1970s]. More room, more time to do that in those days. So perhaps my kind of training was much more the old apprenticeship, although I was a partner …and I probably got my training that way.

And all of the doctors that were interviewed could detail the range of mores and values, medical and non-medical, that they were introduced to by older partners when they first began in practice.

Charles McC: The old man [who was his father and his senior partner] went on until he was 90. Memories of the old man in practice? …He would move heaven and earth for somebody, but he also would throw somebody out the practice that annoyed him. …He wasn’t easily beaten by things… He used to do blood sugars on diabetics in the 1920s… and he was doing this in the surgery.

Paisley’s GPs have historically recruited partners from amongst graduates of the University of Glasgow.

Douglas H: If you were tending to look for a partner in theory you would want to get someone you could work with and thought something like yourself. … When I joined Dr H [in 1954] he was someone I was already well acquainted with and knew I could work with therefore it was sensible to make a group practice of four. He was a year ahead of me in University.

There were other routes to partnership. Jennifer W was returning to practice after the birth of her second child.

Somebody was having a Tupperware Party … and Betty [the wife of Douglas H] said, “Oh Douglas is always looking for … people to help out”. And I said, “Well tell him to give me a ring”. So he did and I went to see him and he asked, “Is your family complete?” I said, “Yes it is” [laughing]. We chatted and I worked there for two or three months and then became a part-time partner. So I worked there from ’73, until, I think, ’92.

34 Oral tradition is the verbal dissemination of folklore from person to person and generation to generation.
37 From GPP interview number 27.
38 From GPP interview number 10.
39 From GPP interview number 16.
40 From GPP interview number 29.
The oral histories typically contained a meta-narrative of improving partnership relationships. In memories of the earlier years senior partners were often recalled as authoritarian and paternalistic.

Robert B: I’ll never forget it, because I was a bachelor for the first six months and got married in my second six months [1964]. But I was reprimanded for buying a fish supper when I finished my evening surgery [laugh] …This was, you know, infradig, you know for a doctor to go in and buy a fish supper…

In contrast younger GPs remember their initial relationships with older partners as markedly less hierarchical and more democratic and egalitarian. Christopher J, who began working with his first partners in 1987, remembered that,

They were stuck in their ways, wild treatments. Sort of hated all change, disliked the College and all that sort of stuff. But at the same time open to change. They were aware of their own failings and what they were like. And they were good and they were caring. They looked after patients and they had a good reputation. And it was just nice; it was nice coming to work for them. … The one who went part-time practiced more the medicine I fancied and the other one, who was the fulltime one, kept it on the straight and narrow as regard to money and stuff like that. But he was very good, if I came along with harebrained schemes he would say to me things like, “You haven’t convinced me go away.” Or he’d say, “Right we’ll do it for six months and see what happens.”

Margaret G recalled working with her husband and a younger partner, Colin R, who continues to work in the practice.

*He [Angus] was a very humble person really … I hope Colin didn’t think we lorded it over him but I don’t think so. We just were his equals.*

Colin R had consciously tried to maintain the values of the partnership. This not only included the way he worked with patients, but also in the relationships between partners.

*There’s no hierarchy. I am in name the senior partner because my name’s at the top of the board. …The decisions are all made kind of, well, either unanimously or at least majority-wise when we have practice meetings. You know I don’t have any more votes than anyone else. And that’s always how it’s been.*

Most GPs can report the partnership histories of their practices with ease. Some, like Colin R, have a keen interest in the history of their own partnerships and practices.

*I was, I think, about the fifth or sixth new doctor since the practice started way back in about 1913. The earliest record we have on a patient is 1913, the earliest actual scribble written down on the old medical record envelope.*

And within the narratives of improvement in partnership relationships there were foundation myths describing the origins of a practice — sometimes involving a doctor whose eccentricities became retrospectively celebrated. Then there were narratives providing continuity in the shared values and beliefs of partners. There were the stories of conflict and compromise between those who sought and those who wanted to resist changes, especially in the ways practice was organised and patient care was delivered.

The age profiles of partnerships have also been significant in the experiences of

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41 From GPP interview number 23.
42 From GPP interview number 02.
43 From GPP interview number 24.
44 From GPP interview number 22.
45 From GPP interview number 22.
change and continuity within practice. For example, in one of Paisley’s larger partnerships, five out of seven of the principals were around the same age. Damian S entered this large, seven-handed practice, in 1978. Innovation only became possible for Damian when the last of the older GPs retired around 1992.

Because there was a group of these guys all the same age, the way they ran the practice was the way the practice was run for long enough. And really the major changes in the practice only occurred within the past three or four years … Again because you’ve got to respect these guys. They’ve been here a long time. … Of course you have. And you can’t just waltz in and expect everyone to change simply because you think what you think is right … and you’d be bottom of the popularity stakes if you tried to. So it was in a way very interesting practicing here when all around you everyone else was following the path of appointments, computers — computers, Good God — computerisation and things like that.

Almost all of the other practices in the town had partnerships with principals drawn from doctors who were of different ages and at different stages in their careers. This not only influenced the ways in which practices responded to change, but also provided the basis for the creation and transmission of oral traditions.

While medical family dynasties have been less of a major feature of general practice partnerships than might be thought, the descriptions of partnerships in the GP interviews were similar to accounts of relationships found in family histories. It was usual, for example, for doctors to describe the history of a practice with a litany of the names (and the fates) of practice partners. Such lists commonly included details from a period prior to the interviewee’s involvement in practice. These recollections are partly based on details from patient records and from memories of partners’ stories, although the memories of other members of the practice team and older patients were also passed on by word of mouth and played an important part in contributing to these, often unpublished, histories.

The descriptions of partnerships also contained metaphors drawn from family life and, to borrow a phrase from anthropology, suggested that partners thought of one another as fictive kin (or members of psychological families). Fictive kinship occurs when people who are not related by birth or marriage have emotionally significant relationships. That partnerships involved emotional investment, as well as outlays in finance and labour, is evident in most of the recordings with Paisley’s GPs. Recollections of practice splits repeatedly involved expressions of pain, bitterness, confusion, and anger for all involved.

It was also observed over and over again that in the early years of joining a practice younger partners were treated like favoured sons or daughters. And successful partnerships were said to be like happy marriages, whereas divisions and splits were described as ‘divorces’.

The existence of oral traditions describing partnership arrangements in terms of fictive kinship, along with the meta-narrative of progress, framed the ways in which changes and continuities in practice ideology could be discussed by doctors and other members of the practices. And these oral traditions also contributed to the identities of individual practices. So, for example, one practice in Paisley that had experienced an early increase in partnership size was known as ‘the crazy gang’. More generally partnerships gained particular reputations both internally and externally, including as

46 From GPP interview number 19.
47 Thompson P. Introduction. In: Bornat J, Perks R, Thompson P, and Walmsley J (eds). Oral history, health and welfare. London: Routledge, 2000: 1-20. Only one of the Paisley’s surviving practices has had three generations of a single family as partners, although there were instances of sons following fathers (pre-1965) in a very small number of practices and there were at least two practices in which husbands and wives worked as practice partners.

48 Many of the GPs have asked that the descriptions of partnerships are either reported with care or not released for specified time periods. Some of the recordings of practice splits cannot be revealed and some I have chosen not to recount, because of the impact they might have.
‘money makers’ or ‘carers’ and as ‘functional’ or ‘dysfunctional’ groups.

Change, especially if driven by younger entrants, could be a source of conflict. In 1979, Andrew K joined two partners who had spent almost three decades together. His problems grew after one of the older partners retired and the other, who was in his 70s, stayed on. They were joined by a newly trained GP.

I turned the guns on what was my friend, my old partner and friend, and we had quite a close relationship before … it went a bit cold, … I distanced myself from, eh, more or less letting him know that you’re not going to run the show here… My [younger] partner he was quite attached to him; he was a loveable rogue. … So I was then cast as the, eh, Big Daddy. That’s what he used to call me, Big Daddy. I was the bad guy, if you like … and he was able to divide and rule very effectively. … My partner that I have now … we’ve been in partnership for about 18 years together. Stormy initially … I felt the draft from him. Initially I sided with this older doctor and the old ways, the comfort of it. Then I realised this is not practical and I shifted allegiance to the new, younger chap and from then on we were a in very good relationship.49

Others also found promoting change difficult.

Fiona T: There was a fair bit of conflict, because of wanting changes and [I’ve] not been willing to wait till everybody was happy …ehem, probably a fair bit of conflict between her [another partner] and I over that. ...Ehem, although at the time I thought it was just the two of us, but it turned out it was everybody [laughs].50

Brian R: So we started talking about things like maternity leave and, ehem, that was just a conflagration, so we basically fell out at the practice agreement meetings. So the practice agreement meetings then became practice disagreement meetings and then they all just fizzled out. So basically we’ve got no written practice agreement.51

And disagreements could escalate.

Carol S: They [splits] weren’t very common at all up to the 1990s. Then there were splits all over the place. …It ended up a two/two split and when there’s a two/two split there’s very little you can do, although there was a Practice Agreement. So it was a very unsettling and not a happy time. Ehem, there are quite a few break-ups in practices. I think a lot of changes. There was a difference in philosophy between John and myself. And [pause] it wasn’t very pleasant, but anyhow, ehem, it actually worked out. It was amazing the coincidences that happen. From me being almost a nervous wreck and wondering what the future held …we had amalgamation. This was quite a bit of time after the break-up.52

John H. remembering the difficulties surrounding the end of his first practice partnership recalled:

My wife was pregnant just about to deliver. Ehem, I had bought a house in Paisley; I was settled here. I made friends here. My wife had made friends, and we weren’t going to just sort of uproot all that. But all that was under threat, I think my whole life seemed to be under threat at the time.53

Finally, a number of the GPs suggested that the most serious disputes between partners have occurred since the introduction of the 1990 contract and that problems were likely to arise as a result of disagreements about practice finance or workload. The fees and allowances system, that improved conditions after 1965, had become a source of conflict by the 1990s.

49 From GPP interview number 25.
50 From GPP interview number 28.
51 From GPP interview number 05.
52 From GPP interview number 08.
53 From GPP interview number 21.
4. Changing practice

Rona Ferguson and Graham Smith

Retired doctors constantly expressed surprise when they witnessed the increasing numbers of personnel that seem to be filling their former premises to bursting point. And the employees recalled by the oldest doctors in the Paisley project belong to a bygone age. For example, at least one of the town’s practitioners boasted a chauffeur, while most engaged housekeeper-receptionists.

For most practices it was the Family Doctor Charter that marked a change in the duties and status of reception staff. This included Robert E’s practice:

Prior to 1966 we had a kind of housekeeper-receptionist. We had a flat attached to the old surgery and we had a family who lived in it. The wife of the family kept the close [the tenement’s common lobby] clean for us and she answered the phone for us during the day. When we formed the group practice and moved to the premises in Neilson Road we no longer needed a receptionist-housekeeper of that kind. She got a council house and we continued to employ her as a receptionist. She was full-time and we had two part-time ones then one of the part-timers became full time that was sufficient for many years. I don’t know how they get on nowadays, but they seem to have a staff of about a dozen in the place now.54

Other GPs, including Patrick McC, claimed to have established an appointment system much earlier than this.

In 1953 we started [an] appointment system … and the receptionists were completely looked after. One or two occasions you got a nasty person in and were told to leave the list. But our receptionists were first class … They are the first people to see the patient; they’ve got to welcome them to the place, treasure them. If the matter seems urgent they’ll push them through. If they look a bit sad and weary give them a cup of tea… 55

What is clear is that there was a great deal of variety across Paisley’s group practices in the ways that receptionists worked and appointment systems were developed.

David R: I always had three receptionists and we were open six days a week and we always ran open surgeries. Because one of things that pissed me off most about the previous practice was the way in which they just came down on the patients every time … I thought it was a dreadful appointments system and it utterly discriminated against the poor. You know, they [patients] didn’t have the same options, because they had to think about the bus connections all the time because they were in the peripheral schemes. And secondly, they didn’t tend to have the phone so all the receptionist had to do was keep them on the phone till their money ran out [laughs]. 56

Practice administration became increasingly important from the 1990s onwards, although different practices have taken different approaches.

David D: When I came here [in 1988] … the practice had absolutely no management structure … we had a book-keeper but the principal seemed to do everything in terms of actually dealing with the genuine business side of things … We did have a manager, probably quite late in the game in relative terms compared to other practices … and then we went through a number of managers with a series of disasters, because we were totally unrealistic about our expectations of the manager. These people came in and they would all have significant strengths in one area or another but be completely disastrous in one area or another. Eventually we got so disillusioned with the idea of having practice managers that we decided to abandon that completely. … We now have a reception manager and a practice administrator.57

54 From GPP interview number 07.
55 From GPP interview number 03. Compare this statement with Damian S’s (GPP 19) presented in 2. Families and family practice.
56 From GPP interview number 06.
57 From GPP interview number 09.
Linda F: So it’s five receptionists and a practice manager… It’s been a gradual thing over the years. I think the first increase was 1990… There’s more forms to be filled in, there’s more things that need to be discussed, there’s more bits and pieces to be planning.58

The employment of new staff has added considerably to the pressure on space within practice premises and even those premises built in response to the 1965 contract began to prove inadequate.

Gerard D: So when we want to bum [boast] we add on two extra rooms. We talk about ‘the office’, the practice manager’s ‘office’ and … we talk about ‘the computer room’. I mean there’s no door to it or anything. I mean it’s a corner in the corridor.59

If the growing numbers and range of staff in practice administration has been largely straightforward, the relationship with medical staff has been less so.

Optimism generated by the idea of the primary health care team recurs in the history of the NHS. In 1948, nurses had expressed enthusiasm when presented with plans for the National Health Service and the opportunities for co-operative working that it promised.60 In contrast doctors initially were less enamoured by the prospect. Today, many doctors are knowledgeable and supportive of practice staff and attached personnel. Nevertheless, there are distinct areas of tension, revealing an ongoing process of redefining professional roles and boundaries.61 While some of the changes inherent in the development of the team can be seen as advantageous, others seem to represent a threat to the position that doctors have traditionally held in the delivery of primary care. The testimonies of GPs reveal numerous issues that can be seen both to underpin and to undermine the primary health care team. These issues include issues of power, status and the skill mix within the practice, as well as wider issues of medical responsibility and professional autonomy. All of these contribute to a reappraisal of the doctor’s own role in an effort to maintain the unique value of being a GP.

The result as been that establishing the primary care team has been slow and there have been difficulties, including communication between GPs and nursing services that reflect wider tensions arising from sharing responsibility for patients.

Perhaps the most challenging realisation that doctors have encountered in the development of the team is the utility of the nurse. The nurse’s expanded role goes beyond taking on medical tasks to include exercising what is regarded within nursing as one of the nurse’s more established skills; that is, social assessment, providing a more holistic knowledge of the patient and the patient’s environment. While nurses seem to be particularly confident in this area, patient care in the community has been seen at different times as an area contested by practitioners and nurses.

Amongst the attached personnel, it is the changing relationship with district nursing and the subsequent growth in the numbers of practice nurses that best encapsulates the fluidity of professional boundaries in general practice. The decline in the doctor’s home visits62 marked a watershed in the relationship between nurses and doctors. In

58 From GPP interview number 18.
59 From GPP interview number 27.
60 See the Nursing Times, Saturday 3 July, 1948, Vol xlv, No.27, p. 471: ‘Nurses are fortunate in being a most essential part of the service. Some nurses have been appointed to help in the control and management of it. The majority will, in many people’s minds, be the service. More nurses will be visiting the homes of the people as health visitors, domestic nurses and midwives. More people will meet the nurse at the clinics, health centres and hospital outpatient departments, and they will judge the service by the personal care and consideration they receive.’ See also ‘Towards a Real Health Service’ in the Nursing Times, Saturday 3 July, 1948, Vol xlv, No.27, page 475: ‘The distribution of individual duties is less important than making sure there is true teamwork. For the first time in our history, the health visitor, the district nurse and the midwife will all be employed, directly or indirectly, by the same employer, the county or county borough council, and will be under the control of the same chief officer’.

the early years of the NHS, the number of house calls requested of doctors increased, placing doctors under a great deal of pressure of time. As district nurses became attached to practices in the 1960s, improved communication and partnership between GPs and nurses saw a decrease in doctors’ house calls as nurses were able to take on some of this work.

The oral evidence suggests that prior to the decline in home visiting doctors were much more ambivalent about the role of district nurses. Doctors were much more likely to view the nurses in a more positive way with the expansion of district nursing visiting and district nursing duties.

Donald W. was asked whether the role of the district nurse had during his time in practice.

You mean did district nurses seem to me in 1964 to be the enemy? Were health visitors the enemy? By that I mean that your district nurse would go out and see somebody in the morning and she’d put in a call in the afternoon, and the same with the health visitor. …So you then found yourself picking up these things, which had been probably known for a while but have now come in as a so-called ‘emergency visit’. And that didn’t go down well… Well this was work that they were introducing at a time when you’d already done about 14 calls that day, and a long surgery, and you knew there was another long surgery coming up, and you were in the process of trying to digest a meal, and they’re on the phone. So, yeah they were looked upon as the enemy [laughs] in that sense.

District nurses are very much part of the team [now] and if there are problems you have a chat with them and when there are long-term problems with people they’re more in charge of the situation really than you are. I mean the health visitor and district nurses I see every day and have a chat with and if there are problems we decide how to approach them and how we should go about it.  

There was evidence of a prevailing ambivalence present in nurse–GP relationships more generally. Some practitioners appreciated that the nurses could save GPs’ time, while others were not entirely comfortable with the extension of the role of nurses. The tension present in the nurse–doctor relationship within contemporary general practice was evident in a number of accounts. While the doctor needed to utilise the nurse’s skill without the added work of supervision, the boundaries of autonomy were blurred, with no clear consensus among GPs of what the nursing role should involve. And the narratives suggested that autonomy was constantly being negotiated between individual members of the professions.

Some of the GPs spoke of having to acquire understanding with individual non-GP colleagues.

David D: I think partly it’s initiative and partly it’s fulfilling a role that complements what we’re doing and obviously you’ve got to complement what they’re doing as well… There’s one of my health visitors that I know when to involve her and she knows when to involve me … it’s a negotiated order, it’s a negotiated position over time.  

It is unsurprising that the doctors in one practice took the decision to recruit staff who had already worked with practice partners.

Fiona T: The two girls who are currently practice nurses are the only practice nurses we’ve ever had. And they both came from our district nursing staff. We pinched them. Ehem, our health visiting staff, has evolved over the years … but we haven’t had a great deal of turnover of nursing staff. … So I hope that reflects that they, feel as if they’re a valuable part of the team.  

The changing role of primary health care team members was evident in the creation of new posts (including specialisation of administrative posts). By the 1980 and 1990s not only had the number of posts in practice increase, but the responsibilities attached to these posts were redefined. For

63 From GPP interview number 15.

64 From GPP interview number 09.

65 From GPP interview number 28.
example, some receptionists became practice managers.

The ways in which medicine was practiced in primary care, including the ‘management’ of illness, had also changed. John H, for example, recalled in the early 1980s discussing caring for patients with Parkinson’s Disease with his trainer:

Now I had swotted up on Parkinson’s disease and seen lots of folk in hospital and I thought I knew everything about it. … And it was very obvious that I didn’t know about dealing with people at home with Parkinson’s disease. “How do you manage this?” And I said, “You give this drug, that drug and the next drug”. And he said, “Well no, that’s not what we really mean by managing it. You involve your district nurses, you get the OT out… and you organise care”.

… And you learn more about teamwork in general practice and they had regular meetings with the whole practice team; the social worker was involved as well. There was a much better relationship between the social work input there.66

For some of the Paisley doctors a growing practice team became a source of status — an indication that their individual practices were progressive and progressing. Others were less sure of the impact of the growing team and reservations were expressed, including the difficulties of managing large numbers of employees. Concerns were also aired about whether the quality of patient care had become compromised, with some of the doctors claiming that more time became spent on the management of the growing bureaucracy of practice that resulted from a larger staff base. Many of the working GPs were to varying degrees dissatisfied with the way their primary care teams had evolved and hinted at their lack of control over this evolution. And there was a sense amongst some of the younger GPs of continuing tensions in the primary health care team.

Graham D: Nurses are very good at working to protocol … but nursing as a whole is underutilised. I think there’s a danger that if we over-utilise them there’ll be less of a job for ourselves being that there is a lot of things that they can do and do very well.67

This feeling that the nurses were doing ‘too much’ was reiterated by another GP with reference to the concerns of dermatologists.

Brian R: The dermatology system is being redesigned and the dermatologists are very nervous about the nurses looking after leg ulcers and having access, if the nurse isn’t happy, to refer directly to the clinic. They would rather that the nurse asked the GP for an opinion and the GP referred to the clinic… The GP’s job is changing all the time. What we’ve got to do is, or I’ve got to do as a GP is, I’ve got to make sure that I’m doing something which is something I can do. For instance, only I can do.68

While strategic appointments of receptionists and nurses streamlined the service, and specialist tasks that were hitherto the province of the GP were devolved to other staff, the doctor remained essentially passive. Perhaps these developments have served to reinforce the generalist nature of the GP and to indirectly raise the profile of the medical skill of diagnosis, which remains firmly in the GP’s domain. The success of the health care team begs the question of the relative value of medical diagnosis, which seemed by the late 1990s to be the only secure place for the GP.

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66 From GPP interview number 21.
67 From GPP interview number 04.
68 From GPP interview number 05.
5. Gender and narratives of profession

Graham Smith

Margaret G: About six months after I was there [c. 1952] I was running up a tenement stair and there were two wee boys playing on the first landing. And one said, ‘Hello Doctor’. I said, ‘Hello Patrick’. And then as I ran on up the stairs he says to his wee pal, ‘That was my doctor’. And his wee pal said, ‘Yer doctor? Was that a man?’ … It was inconceivable to the other wee boy that the doctor would be a lady.69

While a doctor in the middle of his career in the 1990s could claim to have ‘GP stamped on my bum’,70 this was neither the language used nor the sentiment expressed by the older working and retired practitioners interviewed in the Paisley study. For many of the older cohort, professional identity was certainly spoken about in intimate and personal terms, but individual work identities were internalised in ways that were different from the ways in which younger practitioners narrated practice. In particular, in the interviews with retired and older working doctors, hands often featured as metaphors. There were numerous references to an ‘extra pair of hands’ and a ‘safe pairs of hands’ in descriptions of general practice in the years before the mid-1960s. And older GPs used hands not only to illustrate professional competency and commitment, but also to refer to the pragmatic and experientially learnt application of diagnostic and therapeutic skills.

Charles McC: So you had to be able to deliver a baby and delivering a baby was how good your hands were and how good your technique… I was good with my hands, I could fix things, I could deal with things, I could organise things… If you diagnosed from the foot of the bed you’d got problems.71

Robert B: A woman in her mid-60s had come in to see me with a generalised pruritis, but with no rash. And I had taken time to make damn sure there was no rash and I laid my hand on her belly and she had a mass. And I was pretty certain I was faced with a gastric carcinoma and an unusual neoplastic urticaria and I wanted to get an opinion. The surgeons weren’t available and it was Hugh Conway [a physician] that came out and he said, ‘Remarkable. That’s a splendid diagnosis. I’m sure you’re right’. And I mean I was walking on cloud nine. I don’t know why I put a hand on her belly really...72

Gavin W: I’ve always very much believed the hands-on way is the best way of learning.73

The metaphor of ‘hands’ was contrasted in these accounts with theoretical understanding. Patrick McC noted, for example, ‘The medical profession has far too much theory and very little practice; I think they should have more hands-on.’74

These older doctors also frequently referred to engineering as a profession that they or their colleagues might have entered as an alternative to medicine. Douglas H described a colleague in the following way:

His father had been a doctor in the town and he followed in his father’s footsteps in his father’s practice… I knew he was a good engineer. I’m sure at one time he must have had a problem deciding whether to do medicine or engineering, because one of them was going to have to be a hobby… He was good with his hands. He was a good and caring doctor too.75

Engineering is one of the few professions that has material products.76 It is also a profession that has been claimed, mainly by

69 From General Practice in Paisley (GPP) interview number 24.
70 See 2. Families and family practice.
71 From GPP interview number 10.
72 From GPP interview number 23.
73 From GPP interview number 17.
74 From GPP interview number 03.
75 From GPP interview number 16.
engineers, to be undervalued in Britain because of its material products.  

The emphasis on practical matters that can be found in the narratives of engineers was also expressed in stories told by GPs. This included descriptions of DIY improvements to practice premises, with partners commonly installing cabinets and sinks in surgeries and shelving for patient records in office areas. A number of practices in Paisley boasted a partner who was proficient in joinery, and one GP somewhat alarmingly displayed his electric power tools on shelves in his surgery. An earlier study found an analogous pattern in the narratives and values of city businessmen.  

There were exceptions in the ways older doctors talked about their work. GPs who were active College members were less inclined to stress practicality and experience as important. They were however much more supportive of educational initiatives and emphasised the importance of theoretical concepts. Embodied skills and an emphasis on pragmatism were also largely absent from the descriptions of profession and the activities and skills that female GPs provided. And both groups were more likely to accentuate a holistic approach to patient care.

One of the most significant changes to GP narratives of profession has emerged from the increasing numbers of women who have entered practice. Between 1970 and 1990, the proportion of female family doctors had more than doubled, from 12% to 25% of the total, although less than half were working fulltime. It was a trend that would continue in the next decade in both England and Scotland.  

The interviews do suggest that male doctors were less likely than their female counterparts to have family responsibilities, including caring for young children and ageing parents. Retired female GPs also tended to be more reflective about their place in medicine. And only one of the women doctors in the study believed that some of her female colleagues were working as members of what she called the ‘pin money brigade’, adding that she thought that they ‘were playing at being GPs’. The rest were more likely to take a considered view of women in general practice.

Margaret G, like other female family doctors of her generation, worked in more than one practice.

Margaret G: Well, a lot of ladies like to see a lady doctor and it’s more and more accepted now. Not like when I went to Helmsdale, they’d never heard of a lady doctor. And I probably said to you that I thought it didn’t matter in Dumbarton that I was lady. But once when I had to do a Monday evening surgery, which was always done by the two men, there wasn’t a lady in the waiting room. There were these twenty men looking at me when I went in. So that made me think that some men probably didn’t want to see a lady … But once they know you and you’re The Doctor, I don’t think it matters. Well, it’s for them to say, isn’t it?  

Older female GPs recalled general practice as patriarchal and recounted examples of the difficulties women have found in the profession. Some of the women, for example, complained of the lack of space in their practices, being more likely than their male colleagues to share surgeries, even when working full-time. Nevertheless, they also shared a positive view of the profession, and the position of women in


79 See 11: Teaching, training and the transmission of medical knowledge.


82 From GPP interview number 24.
While there was little consensus among the women regarding their contribution to general practice, there was a belief among the older men that it was increasingly important from the 1980s onwards as well as convenient and pragmatic to appoint a female partner.

**Donald W:** ...Something that had been running through my head for a long time. When you have a smear clinic you appreciate that there's a large number of women who don't want to come and see a man for a smear. And also since you find yourself as the youngest of the three having to deal with all of the emotionally upset women, you know, you think "Well, a woman would be a good idea here" [laughs]. And you know it was obvious that that was something that was necessary within the practice and I convinced them that this was what we should do. But we took on a woman as a fourth and equal partner.83

There was an argument that women were more likely to accept a part-time appointment and practices could cautiously expand by taking on part-timers rather than taking the risk of appointing full-time partners.

**Robert E:** Having a woman, particularly a married woman, in a part-time job obviously was an advantage to her as well as to us. When she left us we never advertised again. We always knew of somebody that we could approach…. Eh, we didn't need a full time partner.84

Discord between the genders was reported in a number of interviews. The following is a relatively trivial example, although illustrative of how expectations and subsequent memories could differ.

**Douglas H:** It [the practice partnership] was never unduly hierarchical. No. I only laid down the law once, I think; when we had a female partner. I said, 'She should wear a skirt and not trousers' [laughs]. We're talking 15 or more years ago now.85

I asked whether Jennifer W recalled a partnership dress code.

Jennifer W: [Laughs] Bet you Douglas brought that up? Uuhh. You know he never had to complain. Once I wore a trouser suit. Did he say that? Yeah. And I got reprimanded. I did. And I think I probably told him he had to come into the 20th century. … I always did dress up.

Among male doctors, and even some of the younger male doctors, there was a perception that female practitioners were suited to treating particular patient groups, conditions, and illnesses, including psychological illness. The women also felt that some patients either gravitated towards them, or that their male partners referred certain patients (including children) to them, because they were women.

Jennifer W: You're working to targets, your cervical smears, your immunisations. Yeah, I would end up sending out letters after they had had three reminders. You know hand written. Asking people, you know and explaining how important it was to get the follow-up... and trying to get them back and you know they honestly weren't interested some of them. And it was the same for immunisation. You know, I had umpteen weans [many children] ...there was an awful lot of time spent trying to reach these targets, which I mean initially I could. I am not into the finances of it now, but initially it was 80% cervical cytology and if you were 79% you lost a serious amount of money.

... We had a couple of nuns [laughs] ... that was certainly the ones you got as a female partner.86

Eleanor H recalls applying for her first post in general practice in the mid-1970s.

I went for several interviews and the job on offer was nominally a partnership, but it was a partnership where I would be doing gynaecology and baby clinics and I was not happy at that role at all and I turned down

83 From GPP interview number 15.
84 From GPP interview number 07.
85 From GPP interview number 16.
86 From GPP interview number 29.
several jobs, ehem, on the basis of that... I didn't mind if patients chose to see me but that is an entirely different thing from being told that's your role …

... Somebody did an audit to see what your clientele was like and it was interesting that you do tend to attract people who are similar to you in age. I was the only female partner at that stage… it must have been about ten years ago, and I had a vast range of elderly women who came to see me. I did have the people in my own age range but I had a lot of elderly ladies who chose to come to see me.87

And most of the younger male partners commented on the ways in which patient care could become shaped by having female partners.

Graham D: I have maybe women who attend me for rheumatoid arthritis or whatever it happens to be, but will attend one of the female partners for their HRT, which seems fair enough. I can't relate to that problem.88

There were indications in the narratives of younger women that a critique was beginning to develop in the late 1990s regarding the position of female GPs. These younger female GPs were much more likely than their older counterparts to reject having their identities and their role in practice defined for them.

Fiona T: Well I wasn't ever going to be a lady doctor that was the thing. I didn't want to be a lady doctor I just wanted to be a doctor … They hadn't had a female partner before they had had a lady doctor. And they treated the lady doctor very badly. Very much as a second-class citizen … don't let women sign cheques [laughs].

… I bully them, that's what I do. That's what they would say I am, sure. Ehem, I just go on at them … I think I am maybe fairly forceful about it. But nothing in this place starts unless everybody agrees to do it, so, so bullying is probably too strong a way of putting it.

Whether informal specialisation has developed along gender lines would require a larger study, but it is clear that there was a continuing uncertainty among female GPs about the impact of their gender on patient care. There was also ambivalence, shared by some of their younger male counterparts, about patients' choice of doctors according to gender, often predicated on patients' assumptions about women's specialties or areas of interest. There was a belief, for example, that patients assumed that women practitioners, for example, would or should be more interested in gynaecology or pediatrics.

Indeed, there may be even wider implications to the gendering of practice. Marshall Marinker, for example, has suggested that, in the 1950s, disdain for women doctors and hostility towards psychology was all of a piece with the robust masculine instrumentality of medical sentiment, education and practice.90 In the interviews from Paisley, male doctors' appreciation of the contribution of women to general practice has generally grown over time. However, among some of the younger men there continues to be a preference for treating physical illness, with varying degrees of hostility towards psychology and psychiatry.91

87 From GPP interview number 12.
88 From GPP interview number 04.
6. Changing relationship with secondary care

Graham Smith Malcolm Nicolson

When Joseph Collings conducted his survey of general practice in 1949 he actually met doctors who believed that they must do a certain amount of major surgery or lose the respect or faith of their patients.\(^{92}\) Over two decades later, Frank Honigsbaum, in echoing Collings findings, provided one of the most powerful and influential critiques of the division of British medicine and its impact on general practice. Honigsbaum’s analysis first came to the attention of family doctors in 1972 through an article entitled Quality in general practice, published in the Journal of the Royal College of General Practitioners.\(^{93}\) As with the earlier Collings Report, the article generated a volume of hostile correspondence from GPs, causing the College to distance itself from automatic association with the papers published in its own Journal.\(^{94}\)

One indication of changing relationships in medicine is the confidence that working doctors have in their profession, a confidence that their predecessors lacked.\(^{95}\) And we would not deny that tensions between hospital-based and community-based practitioners have been evident since the formation of the NHS, as they were before. Yet, the oral evidence suggests that among rank-and-file GPs there was a more complex, nuanced, and less universally shared perception of the changing relationships between primary and secondary care.

Certainly there were some older practitioners who continued to recall with bitterness the removal of GPs in 1950 from posts in the local Royal Alexandra Infirmary (RAI).

Patrick McC: I was appointed an Honorary Surgeon to Alexandra Infirmary in 1946 at an honorarium of £100 per year. It worked out at sixpence per appendix. In 1948 the health board took over the hospital and my honorarium went up to £200 per year; an appendix at that time was a shilling. In 1950 the health board settled in their own medical staff and, not being a close member of the medical mafioso of Glasgow, I reckon my chances at 28, 29, of getting a consultant post were zilch, so I abandoned surgery for general practice only.\(^{96}\)

Older family doctors recall that the relationship between primary and secondary care deteriorated during the early years of the NHS.

Gerard D: We were second-class citizens and again in those days [prior to the 1970s] it was not uncommon for GPs to be talked down to…\(^{97}\)

Robert E: I think there were probably some of the consultants who were appointed to begin with came from some of the big hospitals and … possibly among some of the GPs, there was an attitude of regarding them [the consultants] as being the font of all knowledge etc. And a certain amount of deference shown to them…\(^{98}\)

And some of Paisley’s younger practitioners complained that, since 1990, their interaction with secondary care in general has deteriorated. However, the testimonies suggest that the town’s GPs had developed a strong link with hospital medicine in general and the local hospitals in particular. Connections were facilitated by the town’s geography: Paisley was small enough for clinicians to know one another if they wanted to, but close enough for the Paisley hospitals to be bypassed in favour of onward referral to Glasgow.


\(^{95}\) See 2. Families and family practice.

\(^{96}\) From GPP interview number 03. Although Patrick McC was to return later to hospital medicine, see 7: Outside interests.

\(^{97}\) From GPP interview number 27.

\(^{98}\) From GPP interview number 07.
Donald W: I liked Paisley because it was a nice circumscribed area ... You had the various hospitals that you needed within the town itself. You had all the specialist facilities of Glasgow when necessary. You know, it made a huge difference ... you had this small district hospital ... So Paisley's a good place to practice in.99

Hence it was in the interests of the local hospital doctors not to isolate themselves entirely from the GPs in their catchment area.

Members of the RCGP, along with colleagues on the LMC, jointly promoted training in Paisley, and in the 1960s and 1970s clinical meetings involving the hospital's consultants and local GPs were held at the infirmary. In addition, there was a series of less formal lunchtime meetings hosted weekly by the hospital's staff, which the town's GPs could attend.

Robert E: Paisley Medical and Pathological Society ran clinical meeting once a month when the Health Service started. And the hospital [the RAI] got more in the way of better-qualified consultants. They ran the meeting, but the GPs all went to them. It became quite a social occasion ... a discussion and a cup of tea and a blether [chat] afterwards.100

Donald W: Coffee in the board room was going on in the 70s ... [laughs, pause] There weren’t terribly many of us invited to that ... there was only one or two that took advantage of that. Thursday lunchtime ... it was very good, because a consultant in the hospital was brought down and he spoke to us... So you got to meet them there.101

And, even more significantly, older practitioners recall being able to drop into the hospital without warning to enquire about a patient’s progress.

From 1974 onwards the RAI provided a part of Paisley’s first vocational training scheme for GPs. The Paisley scheme was somewhat different from others in the West of Scotland, offering six months in general practice followed by two years in hospital and a return to general practice for six months. It has been claimed that this popular, often oversubscribed scheme promoted closer working relationships between GPs and hospital staff. Although the general practice element tended to be somewhat squeezed, trainees felt that it was a good way of learning about different practices in the town from the perspective of the hospital staff.102 GPs and hospital doctors began to get know one another, partly as a result of so many having worked together as registrars in the same hospitals.

Robert B: Very quickly you get a feeling for the GPs in the area — this is a good lad, you know, I can comfortably accept he’ll be honest with me.103

Of course the minority that was trained outside of the town and its environs did not always find it so easy and other strategies were developed.

David R: Coming to the West of Scotland I found that it was just easier to make friends with other outlanders.104

Increasingly, individual practitioners were also returning to sessional work as clinical assistants in hospital departments, including paediatrics, anaesthetics, psychiatry, and dermatology. There are practices that have provided at least two generations of partners in certain specialities, most notably geriatrics. For instance, in the mid-1960s, partners in Robert E’s practice accepted part-time appointments in the local geriatric units, including the assessment unit and four long-term stay units. Robert was retired at the time the interviews were carried out, but David D, who was working in the same practice, had a clinical assistant post in long-term geriatric hospital care.105

Robert E: The geriatric unit at that time consisted of an assessment unit and ... long-stay units. And the assessment unit

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99 From GPP interview number 15.
100 From GPP interview number 07.
101 From GPP interview number 15.
102 See 11: Teaching, training and the transmission of medical knowledge.
103 From GPP interview number 23.
104 From GPP interview number 06.
105 See 7: outside interests.
had one full-time junior hospital doctor, and … four of us [GPs] looked after the … long-stay units … The hospital weren't very interested in where the general practitioners came from. They would have been quite happy for somebody from each practice. But the new consultant geriatrician, who is there just now, was very keen to have people from the same practice to get the out-of-hours cover taken care of.

David D: There'd been a kind of almost cartel of geriatric jobs, clinical assistant jobs, that had existed when I came here … it does add a dimension to what we're doing here, and means also that we probably are better at keeping up to date in terms of modern medical practice … than we might do if we were isolated in general practice alone …

In earlier years, shared social activities constituted one of the most striking forms of connection between doctors in community and hospital. As well as the local medical society and its regular golf contests, there were a number of local organisations and events, including a dance society that involved both male and female doctors, all providing opportunities for doctors to meet.

Douglas H: In the old days when I started practice and even when I was a resident in the hospital anybody who golfed went on these outings … That gradually changed so it was only people who played golf seriously…

Donald W: And of course I got to meet most of them [consultants] on the golf course.

Such informal networks are recalled as significant in the memories of older GPs and seem at least to have consolidated existing working relationships. There is some evidence that there has been a decline in these activities in the 1990s, although they continue to remain important for some of the younger GPs, including Graham D who began to practice in the town in 1993.

I do other things apart from just organise, it might not sound that way, I've got to know more of them [Paisley s doctors] socially and quite happy to refer things back and forward through organising the Paisley Medical Golf Society…

There were other ways of establishing relationships with secondary care doctors.

Christopher J: I always say to patients, “And what was the doctor like?” … If they didn’t like him, or he was really rude, or whatever, I just didn’t send them any more patients. I just basically work like that … One of the trainees here — her husband was a consultant at the Royal [in Glasgow], [a] vascular guy. So they get a proportion of our vascular patients who go to the Royal rather than the Southern or the Western just because I know him, I can write “Dear Paul” on the letters, which is always nice.

Some claimed that relationships between hospital and family doctors changed when the Royal Alexandra Hospital (RAH) replaced the Infirmary.

Gerard D: …the RAI always seemed a much more friendly open place. Now perhaps that’s my reflection of it because I was beginning to get to know it, go to meetings, occasionally go into the ward … occasionally go to the blue room or the pink room, etc. Go up and see a consultant to talk about a patient … and then the new hospital came along. You know, it seemed bigger, less personal, starting to get … younger consultants that you didn’t know.

Linda F: …There’s not the same friendliness. It’s quite interesting; the staff who were there pre-RAH you still have the same friendly atmosphere with them. There seems to be a greater gulf between the hospital and the GP staff in certain specialties. In others there’s probably closeness. If you can actually find someone at the hospital that you can get to know it’s not so bad.
And there were echoes of the complaints older GPs made.

Graham D: I’ve been trying to foster relations, because I think we’ve got to all work together a little bit more. It’s been harder trying to do it with the hospital, because they still regard themselves as, “We’re the hospital, we’re secondary care, we don’t deal with that sort of stuff.” But I’ve been involved in the Drugs and Therapeutics Committee and … RAH informal meetings with GPs.114

Older GPs, like Charles McC, noted the ways in which patient care shifted with increasing specialisation.

And it is very obvious in general practice that you have got to watch a patient who is attending a specialist unit because they can be sitting with something which is nothing to do with their speciality and nobody aware of it.115

While those who were in the middle of their careers mid-career and younger, like Christopher J, have witnessed the movement of care back into the community.

I just don’t refer anyone to hospital with hypertension any more, diabetes — a large amount is dealt with here. Asthma is dealt with here. … We do more investigations before we send people to hospital nowadays. Hospitals send people out earlier; we have more postoperative care … Long-term care in hospital is reduced. They have emptied the psychiatric and long-term stay wards and those people, now in the community, have to be looked after.116

According to the working GPs who were interviewed, the impact of policy change in the past decade has been significant, although it is a significance that was argued over. The ways in which fundholding, for example, has shaped the relationship between primary and secondary care was disputed and there was no sense of agreement regarding the effects of fundholding at the time the interviews were carried out.

Brian R: But to my mind it [fundholding] didn’t really produce consistent patient care, because all that happened … in this turbulence … the other practices who weren’t fundholding did get a second-class service.117

Christopher J: If they’re [hospital consultants] all awful I send them to a different hospital. And that’s why the commissioning is good … up here [in Scotland however] we have responsibility without power.118

Donald W: ‘We took the first run of fundholding. Never any suggestion that [we’d take] the second run of fundholding, with contractual arrangements with the hospital for admissions and so forth. There was never any great point … in this particular close area here.119

In conclusion, the oral evidence from Paisley is at odds with the view that there was an inevitable and deepening division between hospital and community medicine in Britain in the second half of the 20th century, as Honigsbaum has argued.120 Of course, there were stresses and strains, particularly as regards improvement in access to various hospital-based technologies,121 which was as welcome in Paisley as it was to family doctors elsewhere. Nevertheless, a significant section of Paisley’s GPs not only reported good relationships with their local secondary care colleagues, but were also able to provide evidence of close associations.122

114 From GPP interview number 04.
115 From GPP interview number 10.
116 From GPP interview number 02.
117 From GPP interview number 05.
118 From GPP interview number 02.
119 From GPP interview number 15.
121 See 10: Therapies and diagnosis.
122 This section was rewritten, expanded and as Smith, G. and Nicolson, M. Re-expressing the division of British medicine under the NHS: the importance of locality in general practitioners’ oral histories. Social Science and Medicine 2007, 64, 4, 938-948.
7. Outside interests

Graham Smith

Extra-contractual work, or ‘outside interests’ as some practitioners put it, has excited little interest among historians of general practice in Britain. And yet such activities have remained a constant feature in the working lives of the three generations of Paisley doctors that were interviewed. At the time of the interviews, partners in at least nine of the town’s 13 practices were participating in either medico-political activities, education and training, or in some other type of paid non-General Medical Services (non-GMS) provision.

There were only a few practices with partners who were not engaged in non-GMS activities. And some of those expressed an interest in finding non-GMS work.

Linda F: We don’t have any outside interests in the practice … I think in a bigger partnership it’s much easier to have outside interests. … Probably going to look at that in the next six to nine months… I think it is very good to have outside interests. We all see the place for it.

The doctors frequently described these activities as adding variety to everyday working lives in general practice, as well as providing an important connection with developments in medicine and in the delivery of medical services.

Stewart McC: I’ve been the club doctor for St Mirren for longer than I care to remember, since 1978 … Fortunately the assistant manager at that time was also the physiotherapist … [and] he had spent a long time in football … Then we had other physiotherapists who were all very good. I have enjoyed it; it’s good fun …

For over 60 years GPs have not only provided the local professional football team with a doctor, but also the town’s police surgeons, social care agencies with medical services, and private nursing homes with medical cover. While some opportunities have declined, including medical posts within industrial companies, from the 1960s onwards, new posts became available within a growing range of hospital specialisms.

More recently the number and range of medico-political positions have also increased and Paisley’s family doctors continue to represent colleagues on the Local Medical Council (LMC).

Robert E: I think it was 1953 or 1954 before I joined … The 1966 business … a lot of turmoil and various different questions being raised … [Then] when they proposed to have a health centre in Paisley with 40 odd doctors. The proposals were … to have one huge health centre and there were certainly a lot of objections to that idea and then it was decided to split it and have two health centres …

In the face of opposition the health centres were never built in Paisley. Other issues, including resource allocation, continued to face politically active GPs in the 1990s.

Carol S: The managers don’t have the resources … So that was the reason I went on to the GP-Sub and LMC … frustration at things not being done. And it’s also quite good to work on the inside to know what’s happening.

The sheer variety of posts is only matched by the enthusiasm that GPs often expressed about the work they undertook.

\[123\] From GPP interview number 18.

\[124\] From GPP interview number 30.

\[125\] From GPP interview number 07.

\[126\] From GPP interview number 08.
Education has been particularly important for Royal College of General Practitioners members in Paisley since the 1960s.127

Douglas H: I went into practice in Paisley in 1954 and I joined the College in 1957, but that was all I did initially ... The College had started student attachment schemes and I became Chairman of the Faculty in Education after a couple of years as secretary. Bobby E [1969 to 1972] ... his track went more medical-political, but I couldn't see myself wearing two hats, I had to just wear one and I avoided the medical-political side altogether. There were a few [GPs] that stood out as caring and wishing to improve quality.128

New organisations emerged in the 1990s including Renfrewshire Emergency Medical Services (REMS, the out-of-hours co-operative).

Graham D: We had a few meetings that had been organised by the LMC, went along to that initially and had volunteered that I would be very keen to get involved ... I think we weren't REMS then, it was REDS, Renfrewshire Emergency Doctor Service, but that was dropped because of the eventual connotation of REDS under beds and all this kind of stuff; it was like some kind of paramilitary Trotsky organisation...

'We drew up the ... protocols, trained up the nurses, sold it to the GPs ... We had said, “Join and join at the start ... this is a co-op”. ... And we did it on a sort of collegiate vote system ...'129

There was also the Local Health Care Co-operative (LHCC), and a number of community-based health initiatives, such as Have a Heart Paisley — a project funded by the Scottish Executive. As a result of their involvement in such activities, GPs knew more about each other's partnerships than would have been the case in the past and there was some evidence of an increase in inter-practice co-operation in the town. In addition, new opportunities were developing for the doctors involved in these structures. One of the key organisers of REMS, for example, left practice to take up a post with NHS 24 (the Scottish equivalent of NHS Direct).

Such initiatives were built on an earlier history of activism that involved smaller numbers of GPs and a smaller range of organisations, including the LMC and the Royal College of General Practitioners.130

The oral testimonies suggest that there has been little rivalry between the leading activists of the RCGP and the LMC in the town. Instead, a spirit of close collaboration, mutual respect, and a common goal of improving general practice marked recollections.

While the range of 'outside interests' has been important, the paid medical posts in both the private and public sectors have also shaped the development of general practice in Paisley. Of these, it is the hospital appointments that have proved especially significant, according to the GPs. The earlier removal of family doctors from hospital posts in the years immediately following the formation of the NHS could have contributed to the divisions within British medicine, but there were other factors at work.131

Rather exceptionally, Patrick McC, who had been one of the town's GPs whose services in the local hospital had been dispensed with in 1950, returned to hospital work some 20 years later after successfully training in anaesthetics:

Patrick McC: I got bored with general practice; I missed the smell of ether ... that's why I went back in to the hospital service ... And then I gave anaesthetics at Southern General Hospital [in Glasgow, from 1973 to

\[127\] See 11: Teaching, training and the transmission of medical knowledge.

\[128\] From GPP interview number 16.

\[129\] From GPP interview number 04.

\[130\] As noted earlier College membership in the town has been important See 1: Setting, methods and analysis.

\[131\] See 6: Changing relationships with secondary care.
1977]. I did four-elevenths of a full-time job there, combined that with general practice. So I was if you like seeing Annie Muggers with a blister on her toe and an hour later I was anaesthetising somebody in a major car accident.132

His younger brother, and practice partner, also returned to study.

Charles McC: I did a year ... half-time in paediatrics... My retentive ability was terrible. But, then ... I had my physiology book on tape, reading it and putting the emphasis, as I wanted it ... A whole book was on 24 hour-long tapes, and I used to go through them every fortnight, a tape on physiology and a tape on paediatrics and I [when he was around 47 years old] just plagued my brain ...133

GPs with hospital appointments have argued that sessional posts have allowed for positive relationships to develop with hospital doctors and for GPs to remain in touch with hospital medicine. It is also worth noting that many of these posts, unlike those occupied by the McC brothers, belonged to the areas of medicine that have traditionally been viewed by hospital doctors as having a relatively low status (including geriatric care, dermatology, and mental health care).134

These developments contributed arguably towards an informal specialisation of general practice. Some practitioners, for example, talked about either attracting particular patients or have had patients with certain conditions referred to them by their partners, because they deal with such conditions or patients in their hospital posts.

There is also unease, with the GPs often describing outside interests in negative terms. Some younger partners engaged in the less lucrative organisational developments have found themselves in conflict with older partners who are engaged in paid work. One GP who found himself in this position characterised his practice as ‘money-minded’. Another practitioner recalled a former colleague and GP trainer, who left general practice in the 1980s as a result of the pressure he felt from his partners. In part, such anxieties contribute to a shared concern that care needs to be exercised regarding the amount of time and energy expended on organisational activities, or as one GP noted, it is...
necessary to ‘keep life manageable’.  

Andrew K: He [a senior partner who retired around 1980] did outside work. He worked … doing war pensions, industrial injuries and really he regarded that as equivalent to another thousand patients … He brought that money into the practice. Yeah. … There are two things that … break up practices, workload and money.  

Medici-political organisational work was not as well remunerated as other types of non-GMS activities, but it could still generate similar pressures.

David D: I also have become very much involved in the Local Health Care Co-operative since its inception just over 18 months ago. In terms of the time that I'm involved in that now it is absolutely enormous. In terms of the income that accrues from that it's not very enormous, but I still see it as quite important work …

I’ve got a long list of projects and committees that I seem to be tagged onto at the moment with varying degrees of workload attached to that. I’m reasonably comfortable with that, because it’s been new and different and it’s something which I would immodestly say I was quite good at and it’s been quite a discovery for me … So, I’ve really very much enjoyed that and been very loathe to let that go, although at times it’s just about as much as I can cope with because I’m still doing all my GMS work here … and we are very busy here. It’s a big practice and we have big lists and there’s no mechanism for reducing the commitment…

In contrast, paid posts can provide an important source of additional income. Although, among some of those engaged in paid posts there were worries that outside interests could detract from NHS duties. In conclusion, it is interesting to note that there was a recurring emphasis placed on the ways in which finances from external work were used to pay for initiatives aimed to help NHS patients. Working in such a mixed economy seems to produce stress and strain for the profession.

Carol S: We look after the hospital for mentally handicapped and there’s a lot of physical illness there … it’s emergency cover … And we get paid so many sessions for that — that’s what I was saying, the jam on the gingerbread. It lets us for example pay the girls [clerical staff] more money than we’re being reimbursed … you were able to perhaps do a little more for your NHS patients doing that work … It seems a bit daft…

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135 From GPP interview number 09.
136 From GPP interview number 25.
137 From GPP interview number 09.
138 From GPP interview number 08.
8. Patients and populations
Graham Smith

In the past 50 years the transformation of the doctor–patient relationship in general practice has included a reduction in patient deference, the decline of the ‘traditional personal intimacy’ of the doctor–patient relationship, and the increasing effectiveness of general practice medicine which, along with an arguable rise in the culture of consumerism, has helped to raise patient expectations. Examples of these and other changes in society, in patient attitudes and in general practice provision have been charted and illustrated using oral evidence. If, however, the voices of Paisley’s practitioners are heard, no only is this known history confirmed, but new insights can be gained, including the qualitative changes in the relationships between doctors and their patients.

Older retired GPs in the Paisley study enthusiastically talked about the home visiting in the early years of the Health service. Home visiting was once a central feature in the family doctor’s day. Hector M, who entered practice in the 1940s, noted:

There was a lot less trivia in these days. People only went to see the doctor if they had to and home visits were done on a regular basis… return visits to chronically ill people were done once a month… “I’ll just look in and see you next month”, so you did. It was much more friendly and you knew your patients.

And just as often the oldest GPs were significantly silent about the work they carried out in their surgeries at that time. Partly, this is because these doctors wished to emphasise their belief that the subsequent decline in house calls was a significant loss to general practice. But it also seems that seeing patients in their home environment was pleasantly different from the demands of a surgery full of patients in a time before appointments, and with only limited access to diagnostic tools and therapies.

Damian S: At the time it seemed quite fair, but on hindsight … it was bloody unfair. It was shocking in fact. So for the first year or two of Mondays [circa 1978] you were seeing 30 people in the morning, ten or 15 house calls depending on summer or winter, and 30 people in the evening. You got to learn to consult very quickly. … Well, as I say, the old adage “I saw thirty people today”. Nobody ever says, “I saw and examined thirty people today”.

Unsurprisingly older GPs often described their involvement in obstetrics in positive terms. In these narratives doctors are appreciated by expectant mothers and their kin for being available to help and for at least being potentially useful.

In the late 1950s Charles McC joined his father and older brother in practice.

Home births was where you got to know the patient. You sat up with the patient and you delivered the baby. You’d had a cup of coffee and a smoke. I smoked in those early days … It was exciting …

When you’re young in medicine you like excitement … You had to be kind to people that weren’t all that capable of defending themselves. It is easy to beat someone who has got no defences.

My old man used to make the comment, “Never oppress the poor”. And the oppression of the poor was quite an interesting concept, because it went through a lot of things. For example if some old buddy [resident of Paisley] offers you a cup

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141 From GPP interview number 13.

142 See 10: Therapies and Diagnosis.

143 From GPP interview number 19.
of tea. It’s a kind of miserable looking cup. You don’t particularly want the tea, but you damn well sit down and have that cup of tea, because you are otherwise offending the person who is offering you hospitality … you had to respect people’s dignity.  

Disappointingly for most of these practitioners in the space of a few years of their entry into practice the several hundreds of home births that partners in a medium size practice could find themselves attending were all but ended and hospital medicine had taken over a task that they believed had been central to family doctoring.

The enjoyable drives in a relatively traffic-free town to call on reasonably undemanding patients’ in their homes had given way during the 1960s to an escalation in house calls, fuelled at least in part by the growing numbers of patients with access to telephones. Some of the GPs point out that they felt obliged to respond to this demand, rather than risk patients’ complaints, regardless of whether a visit was clinically indicated or not.

Donald W recalled that when he joined another Paisley partnership.

…the demands for house calls in the 60s hugely outweigh anything that we get now …. and a vast amount of that would be just trivia. And while it’s important in getting to know the background of people, if you’ve got a lot of calls to do there’s too much pressure on you to actually appreciate that.

Those who entered practice from the mid-1970s onwards report undertaking many less house calls. Home visiting was also increasingly believed by younger doctors to be a waste of their time and, it was argued, more patients could be seen more efficiently in the surgeries that many GPs had recently improved.

David D: At the end of the day doing house calls is just an extremely time-consuming way of seeing patients.

Fiona T: The days of monthly home visits to elderly people at home — I wasn’t ever quite sure why I went back, I left some prescriptions, you know that kind of visit [laughs].

More effective team working, especially with district nurses, further reduced house calls, and in the 1990s some Paisley practices had adopted triage systems that almost eliminated home visits. Furthermore, it is claimed that at the same time the out-of-hours co-operative encouraged patients to make daytime visits to their own GPs. Even those GPs — and there were many in the town — who found pride in practising with care and kindness reported that they had become ‘a wee bit harder … less tolerant’ with patients who failed to keep appointments at their surgeries.

However, the decline in home visiting and the rise of the surgery appointment has not always been straightforward as this GP recalled.

Patients are less demanding because they are now being conditioned. Now I think for a couple of years before we came into the

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144 From GPP interview number 10.

145 From GPP interview number 09 and From GPP interview number 28.

146 See 4: Changing practice.
practice in 1975 they had been using the deputising service. Shortly after we came into the practice I got a call one night from a patient, “Oh, it’s you doctor, Oh, I thought it was the emergency doctor that was on, Oh, I’ll wait till the morning”.  

By insisting that general practice was more efficient if patients were provided with appointments to attend surgeries and clinics, GPs increased their daytime workloads and decreased the time between consultations.

The doctor who listened to non-medical problems remained a valuable resource to patients, according to a number of the Paisley GPs. In making such claims, parallels were drawn between the pastoral role that was once filled by organised religion and their own work as GPs. Many of the GPs expressed a strong sense of egalitarianism in their descriptions of the doctor–patient relationship and some of the younger doctors stressed that they maintained a sense of patient advocacy that had been more of a feature in the work of the older generation.

The oral evidence also suggests that even in a town such as Paisley, with multiple deprivation, some practices were much more likely to have a patient population drawn from the poorest sections of the population. Indeed, the majority of working practitioners were keen to stress the value of having a patient population that was socially mixed.

Fiona T: It’s a lovely [practice] population of two, three at least, generations of families. They stay very, very loyal to the practice … Very much spread across the town … the geographical spread and the social class spread of the practice … I think it’s nice not having an imbalance. I think it’s good to have a variety of folk.

Robert E recalled one of the first practitioners to establish a practice outside of the town centre.

And a lot of the doctors in Paisley were quite pleased, because they got rid of a lot of patients who had been giving them a lot of hassle and trouble … It was a very [pause] deprived part of the town … Took quite a

If time is the ‘real currency of general practice’ then it is the currency of a token economy, with practitioners historically insisting that their patients value their time as precious. The GP narratives suggested that patient behaviour required moderating by rewarding or denying patients doctors’ time. Commenting on the replacement of the commercial deputising service by an out-of-hours co-operative in the 1990s, Christopher J. reflected:

The difference the [out-of-hours] system has made is that people phoning on a regular basis get the same message about when

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147 From GPP interview number 11.
149 From GPP interview number 02.
150 From GPP interview number 28.
few of them off their hands and then he took on a partner. They have both retired and there’s two or three new people there whose names I don’t know at all.  

For a number of years Dr Wasim B and his two colleagues served the most deprived area in the Argyll and Clyde area. In 1999 the practice was unique in Paisley in offering patients appointment-free, drop-in, daily sessions.

In the long run the patients are you know, quite good. I mean they can be tamed, or they can be civilised through certain aims. Because we treat them like human beings — some of them — that doesn't mean it’s a general principle. Some of them like alcohol, drugs ... We had a lot of difficulty in convincing them that some of the drugs are harmful to your health. You know an individual who used to come to consult us and they were forcing us to prescribe some of the drugs and there were some bitter relations between the patient and the doctor.

Others share his enthusiasm.

Andrew K: We were the second most deprived practice in Paisley ...We have more than our share of social class V ... I enjoyed working here, because ... your own background is relevant in a situation like this. I could identify very strongly with the people in the practice ... solid working-class people. So I have a great empathy with them ... I had no difficulty eh, transferring into this environment because it’s something that I was used to ...

Because you have so much power in that situation, you have to be careful that you don’t become superior, because the patients are vulnerable anyway. So I think you have a bigger responsibility treating people from the lower social class. ... I would say I do feel happier dealing with this section of the community, because it is worthwhile. Having said that I wouldn’t like to be working in a very deprived area and nothing else but that but having a, what we have is quite good.

... You could lose your humanity towards people, because your treating them less than yourself and when you start doing that your own values begin to go and you start looking down on people ...

While there was an acute awareness of the depths of deprivation in Paisley, there was little sense of agreement about how general practice could, or even should, tackle such poverty. Some of this ambiguity seems to have arisen as a result of the rise of a patient-centeredness and the emergence of 'mass medicine', which appeared to be more easily practiced with 'mixed' rather than 'deprived' populations.

“Went on fire, as they say in Glasgow” (A flat on Espedair St, Paisley)

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151 From GPP interview number 07.

152 From GPP interview number 14.

153 From GPP interview number 25.
9. Record keepers

Elizabeth Mitchell and Graham Smith

While the technical aspects of record keeping have attracted much attention, the social and historical contexts have been neglected. A definitive report on quality assessment in general practice, states that primary care records are ‘more than an aide-mémoire to the doctor or nurse’; indeed, good quality record keeping has been regarded as an ‘essential aspect of care’. In addition, since the 1990s, practices have had to demonstrate high standards in record keeping as a condition of training practice accreditation. David D. recalled his practice being threatened with loss of training practice status if the practice records were not brought up to standard.

I’m not sure to what extent other partners felt that they had their notes up to date but I don’t think even they were feeling that they were 100%. So I think we were given a year to get ourselves sorted out before we were knocked back completely, but we used that year to, to get everything up to scratch and did actually get reaccredited after a year but we went a year without a trainee …

However, the record continues to serve a multiplicity of functions, and there remains a great deal of variety between practices both in degree and use.

Doctors who began in practice before 1948 have claimed that they made little use of records and relied on their memories for patient care. It was only with the development of educational initiatives, mainly by the RCGP, that the importance of record keeping in longitudinal care became more widely accepted by practitioners. Even if GPs had been convinced of the need to keep more detailed records — and most were not — there was little in the way of infrastructure in practices for storing and maintaining large volumes of paper records.

By the 1950s, records were still infrequently referred to, but were more likely to be used to monitor the workload of individual partners, especially regarding house calls. A decade later, however, some practices were adopting new approaches to record keeping, linked to attempts to persuade senior partners to abandon strict adherence to individual patient lists.

Donald W: Records are a very useful tool … how you previously treated people, whether it worked … When I joined this practice [c. 1964] there were two other doctors … and they both had their records in their rooms. It took me a couple of years, but I got them all amalgamated … It was a very personal list system … If you’ve got records you actually know that these are your patients, because before people used to walk in the door and you didn’t have records for them, but you treated them. [Before] they didn’t know that they weren’t your patients.

Yet, the pace of change was uneven and as late as the 1980s some practices in Paisley continued to keep patient records in ways that would have been recognisable to practitioners in the 1930s. One GP, Andrew K., for example, recalled an older partner making the joke that, ‘Someday we’ll get those files out and find out what’s wrong with the patients’.

We had Lloyd George and we kept them in cabinets... now these were our receptionists’ … pride and joy and not taken out at any time. They were stored, everything was stored there, but we never

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154 Even promisingly titled papers are disappointing in this area. See, for example, Gill GM. Chaos in A4 records in general practice. Health Bull 1981; 39 (3):153-156 — a paper that has more to say about shelf sizes than the understanding and use of records.


156 From GPP interview number 09.

157 In both this study and in the earlier study The Oral History of General Practice in Britain, c.1935-1952. Also funded by Wellcome, the recordings are archived at the British Library’s National Sound Archive.

158 From GPP interview number 15.
used the files. The files were not brought out for us to use. So I didn’t have [as a new doctor in the practice] any knowledge of the patients coming to see me. The patients would come with all their bottles, with all the medication, and say, “Doctor, that is what I’m getting”, and I would just write out what the medication was. But we never got the files out. The partners’ attitude at the time was, “Well we know the patients, we don’t need files, we, I’ve known them all their life … why would I want to write anything down?” …We kept the letters that came in from the hospitals in a pile, which just got bigger and bigger…

The files were only taken out when a younger partner, with a general practice training, joined the partnership in 1982.\textsuperscript{159}

Although use of the A4 record was trialed in the late 1960s and was suggested as a replacement for the Lloyd George envelope in both 1974 and 1977, plans to introduce it as the standard throughout the UK were never fulfilled. In 1983, however, it was offered to practices in Scotland. In the Paisley study, A4 records were identified by older working, and recently retired, GPs as a key change in the history of general practice. These GPs were responsible, and often took part in, transferring patient records from Lloyd George envelopes to A4 folders. This they believed added significantly to their understanding of individual patients.

By the end of the 1980s most Paisley practices either already used or were engaged in converting to A4 records.

\textit{Eleanor H:} I mean we spent weekends [in 1982] transferring notes and the whole team was involved; you know receptionists, practice manager, and partners. We just all came down over several weekends and just transferred all the data … and of course it wasn’t just a question of transferring the notes we had to get shelves built and re-organise the storage space.\textsuperscript{160}

\textit{Carol S:} We moved [premises] in March ’87 … We took hundreds [of records] home. Months and months. I did most of them. About that time about five or six thousand [short pause] … It was hard work and it had to be done and it’s important to do it; good records make a huge difference. But it was very tiring doing it all yourself. They were transferred immediately but then they had to be summarised. You know they would have been in the Lloyd George envelope so they would have been, we put them into their new envelopes, filed them, but then we systematically had to go through every single one and summarise it.\textsuperscript{161}

The testimonies suggested that there are differences in the ways Paisley’s GPs have used A4 records. Even with the possibility for greater completeness that the A4 record system affords, most of Paisley’s working GPs are aware that they continue to rely a great deal upon their own memories and that of colleagues, particularly in recalling community and kin relationships.\textsuperscript{162}

Electronic record keeping had emerged in parallel with manual systems, but its use in general practice only became more widespread in the 1980s. The 1990 contract emphasised patient targeting and disease

\textsuperscript{159} From GPP interview number 25.

\textsuperscript{160} From GPP interview number 12, GPP interview numbers 07, 09, and 22 offer very similar accounts.

\textsuperscript{161} From GPP interview number 08.

\textsuperscript{162} One practitioner claimed that he knew of ‘practices who have kept family folders’. From GPP interview number 30.
prevention, linked remuneration to practice activity and, as a result, encouraged further adoption of electronic records. Not only did practices need to identify groups of patients by age and sex, they now also had to identify them by disease. Categorising and identifying patients in this way is quicker and easier with a computer and this, together with the Department of Health’s offer of 50% reimbursement on costs, led to an increase in the number of computerised practices, from around 30% in 1989 to over 60% in 1991.163

Paper records, according to Paisley’s younger practitioners, remained useful for a number of reasons. Some believed that paper-based recording increased in the 1990s as a result of fears of patient litigation. Others highlighted the deficiencies of electronic recording and argued that paper records complemented the doctor’s memory of patients (often and somewhat ironically referred to as a ‘database’). Longitudinal care encouraged memories of individual patients to be rearranged, or retranscribed, over time, while the paper record built layer upon layer with each medical encounter. In addition, handwritten paper records provided the practitioner with opportunities to recall consultations and patients with a detail and depth that electronic recording would struggle to match. Not only did paper records allow for uncertainty and speculation in ways that electronic coding systems do not, but re-reading handwritten records offered the possibility of recalling the context of particular consultations, including the state of mind of the practitioner. Hence some of the doctors pointed to the idiosyncratic aspects of record keeping.

Fiona T: In the time it takes from calling them [patients] to getting them through I have at least scanned quickly through their summary sheets, their last consultations, their drugs and their hospital correspondence ... I make notes ... they may have told me about employment or something like that; things that, that build up a picture of them as a person. I also make notes about my plans for their management ... I have got a way of putting that down within the written notes that reminds me the next time ... that was what I was going to do, but I may not have told them. Or if it [the note] is in a different place I will have discussed it ... Other partners may not understand my systems. It's my system [laughs].

It's one of the reasons that I am nervous about the concept of a paperless practice, although not negative about it. But anxious that, you lose that subtlety of where you wrote it, or how you wrote it. What size you wrote [laughs] I don't know ... Something they have said, you know, that you maybe want to explore a bit more ... I haven't got secret signs but definitely sort of occasionally put a wee underline or something beside it to say next time they're in, push that area a little bit further and see if they can find out what's going on. How do you do that on a computer screen?164

David D: I link patients to an address. If I see them at home on a regular basis I certainly link them to an address. And, it wouldn't be the first time I'd have gone to someone’s previous address eh because I still link them to that ... I don't know that I see, "there's Mrs Stroke" or "there's ... Mrs Neurotic" ... I'll probably be able to name first and then follow on that with some aspects of their medical history ... All too often it's “nutter”, you know [laughs].165

Other GPs were acutely aware of the limitations of records, whether paper or electronic.

Colin R: There's also thousands of snippets of information that we know about patients that isn't in the records — you know, who their auntie is. You know, we have one patient — I think he's dead now — but I mean he was a bronze medallist in the 1924 Olympic steeplechase. Right. Now that's of no relevance really to his medical history but it's a nice wee thing to know about the person. So that's not in the summary but that might be in his records somewhere. You


164 From GPP interview number 28.

165 From GPP interview number 09.
know, one of us will have written it in. I wrote in about one patient, “She traced her family back to the Spanish Armada” … That’s general practice as opposed to the bald facts — diabetic, thyrotoxic, hypertension. So the computer doesn’t tell you the whole story ...

Well you see the other thing is you store [in memory] lots of information about patients which comes from extraneous sources … You know you store it in your head and it’s not written down. I mean I suppose if you were to write everything down the records would be enormous.\textsuperscript{166}

Margaret G: Oh well that doesn’t go into any envelope or A4 or anything else. That only comes with growing up with the practice and is invaluable. But you can’t hand that down to somebody. You see if a man of twenty has bad indigestion, well you have to look into it, but if you know that his grandfather died in their house with cancer of the stomach, well there is no way that can be written down on his [the young man’s] case sheet to tell a stranger [pause].

But if you know that you can think maybe he has indigestion from something, maybe he is worrying that he has cancer like his grandfather had. Ehem, when very often that was the case and if it’s brought up then he is reassured [and] the indigestion got better … A man dies of cancer of the stomach you’re not going to put [that] into a grandson’s sheet … and that is where the family doctor comes in.\textsuperscript{167}

More than 30 years ago the role of the GP was described as a ‘clerk’ of a community’s ‘records’ who ‘represents them’ and ‘becomes their objective (as opposed to subjective) memory’.\textsuperscript{168} In the intervening period there have been fundamental changes in the doctor–patient relationship\textsuperscript{169} and practitioners are now much less likely to take such a central part in the populations they serve. However, whether aided by paper or electronic record keeping systems, doctors’ memories of patients and their social contexts remain significant to patient care.

\begin{small}
\begin{itemize}
\item \textsuperscript{166} From GPP interview number 22.
\item \textsuperscript{167} From GPP interview number 24.
\item \textsuperscript{169} See 8: Patients and populations.
\end{itemize}
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10. Diagnostics and therapeutics

Graham Smith Malcolm Nicolson

In a study published in 1988, Bosanquet and Leese found that younger general practitioners were much more likely to invest in, and pursue innovations in, their practices than were their more experienced counterparts. These authors described older doctors as more ‘traditional’ in their attitudes, with a firmer commitment to home visiting. Bosanquet and Leese’s study is both exceptional and somewhat limited by its health economics perspective. The question remains open as to how GPs, younger or older, locally or nationally, individually or in groups, have responded to the challenge of biomedical and technological change as it impinges upon their specialty. Has general practice kept pace with biomedical science? The history of this aspect of general practice remains to be written.

Both retired and older working doctors in the Paisley project argued that one of the most important changes in their clinical practice involved gaining access, from the mid-1960s onwards, to a range of hospital-based aids to diagnosis. First and most important was radiology, followed by laboratory facilities for haematological, and other similar, testing. The following accounts are typical of how the older doctors spoke about practice.

Stewart McC: When I started in practice [in the late 1960s] it was x-rays for example. You could send a patient up with an x-ray card on a Wednesday afternoon and get a chest x-ray … or whatever bone or joint x-rayed … Wednesday afternoon was the only time that was open to GPs. Now of course … we have much easier access to the hospital in general, you know.

Donald W: We didn’t have open access to x-rays in the 60s. We didn’t have open access for bloods … If I needed somebody’s chest x-rayed I sent them to the chest clinic. If I thought somebody needed their bloods done then I had to send them up to the medical clinics … The other thing was people’s illnesses weren’t really documented in their records … Mrs So-and-So is hypothroid, because my partner’s got her on thyroid tablets … Now the clinical diagnosis has been made by my partner some time before … but if you want this documented then get the various tests done … by referring them. And a lot of that went on.

These same doctors also recalled that a number of practices in the town had made provision for laboratories in their premises, although not all were convinced of their usefulness and few claimed that tests carried out within practices were as reliable as those conducted in the hospitals. Open access to laboratory and technological aids to diagnosis was particularly significant in Paisley, given that GPs in the town were in the process of resisting attempts to move their practices into two large centres.

While a growing range of hospital-based diagnostic procedures became available to GPs in the 1960s and 1970s, open access was not established as a principle, and the deployment of some diagnostic technology continued to remain in the gift of secondary care. There was also a great deal of frustration among Paisley’s doctors that some investigations were thwarted by the lack of resources and the resultant long waiting times. Examples mentioned were

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171 From GPP interview number 30.

172 From GPP interview number 15.
psychiatric assessments and barium investigations of the gut.

Furthermore, the skills required in dealing with uncertainty in diagnosis and treatment continued to be valued by GPs, some of whom voiced concerns that intrusive diagnostic investigations may have caused more harm than could be justified. There were doctors, like David D, who continued to believe that part of the role of primary care was to defend patients from the excesses of hospital medicine.

I’m referring people with a diagnosis now more often than for investigation. I think that is something that’s changed … I think I’m probably referring people with a much clearer idea of what I’m expecting a consultant to do… There’s always a danger that you can get too caught up in investigations just for investigations’ sake. And if you make expensive investigations too available then I think that there is a risk of that. I could be guilty of that but I can think of other people that would be a lot more guilty of it.173

listed were elective heart surgery, improved pharmacological control of blood pressure and asthma, the revolution in the understanding and treatment of peptic ulceration, and the impact of non-steroidal anti-inflammatory drugs. So for example,

Stewart McC: Therapeutics have [also] changed a lot … There are lots of conditions that have been around for a long time that we really could do very little for and now there are ways of dealing with them. One very simple example of that is if you look at peptic ulcer disease … People don’t do gastric surgery nowadays, you know, they don’t do vagotomies or pyloroplasties. I don’t know when the last one was done but you know it was a long, long time ago and then even better proton pump inhibitors you know and now somebody’s discovered Helicobacter.

… The other thing, which in terms of therapeutics has been helpful, is the development of sustained release … Most people remember to take a drug once a day.175

Changes in drugs therapeutics presented a particular challenge for Robert E and his partners when they took over a neighbouring doctor’s list on his retirement.

Robert E: …The old barbiturates were disappearing [and] … the number of patients that he had started on barbiturates as sedatives before the war and were still taking them! … The number of patients he had who were taking one or two tablets … at bedtime. Thirty years you’re talking about … I remember enthusiastically trying to wean them off to begin with and then I gave up. In view of the fact that they obviously weren’t needing increased amounts, I just gave in and gave them scripts …

… I never really wanted to be the first to do anything. Eh, I didnae want to be the last to give anything up … With regard to things like treatment for lowering blood pressure … I think I was quite enthusiastic at trying everything that was new, when I started off,

173 From GPP interview number 09.


175 From GPP interview number 30.
and became more circumspect in later life.\textsuperscript{176}

Above all else, however, it is the move from curing to long-term caring in primary care that the practitioners discussed and, in particular, the difficulties that this entailed in the context of earlier hospital discharges, tighter budgetary control, and rising patient expectations.

Some changes have been less visible to practitioners, including the growing acceptance of psychology and psychiatry in some practices.

The oral evidence also suggests that mental illness continued to pose particular challenges in general practice. Even after the introduction of more effective psychotropic agents, from the 1960s onwards, many GPs found the treatment of the mentally ill difficult. Our Paisley study suggests that, whereas female practitioners were often more willing to advocate a holistic view that embraced the management of psychiatric conditions, their male colleagues were much more likely to state a strong preference for treating physical illness. Indeed, hostility towards psychiatry, both during education and in practice, was evident among male GPs of all ages.

Linda F: I mean my own feeling would be that no-one should be able to go into general practice without having done six months in psychiatry. That’s my own personal bugbear.

Charles McC: The one that really got up my nose was psychology. I mean I think it happened to the whole class.

David D: I just completely hated psychiatry and that was a serious low point in my career [laughs].

Brian R: But psychiatry and I didn’t get on, because I like to have things regimented and ordered and psychiatry is not like that. In fact I got a pass/fail oral in my psychiatry, which was a bit of a shock to me.\textsuperscript{177}

There were of course notable exceptions to this and the oral evidence also suggested that particular group practices from the 1980s onwards developed a more positive approach to mental health, including a willingness to engage with drug dependence, self-harm, and similar issues. John H worked in one such practice and noted:

I don’t have any hostility towards psychiatry. In fact we do a lot of psychiatry in here. We’re high prescribers of antidepressants.\textsuperscript{178}

Similarly, some partnerships were historically much more likely to be interested in purchasing diagnostic equipment. And there were expressions of enthusiasm for technological development. John H, for example, recalled a senior partner in a practice in which he himself was once a partner:

John H: His idea was to have almost a kind of one-stop place there where you would have an ultrasound machine and you would be able to do everything for the patient on the premises. And I think that’s fine, I think that would be a good way, but only if that’s the way things go … But I think we’re more generalist here. I think it’s more relaxed here as well.\textsuperscript{179}

Such enthusiasm was particularly evident among younger GPs.

Graham D: Well I think things like it would be nice to get a new ECG machine, ehem Histofreeze, we use Histofreeze just now, but we’d like to use liquid nitrogen minor surgery. In fact I’ve got my list sitting up on the wall there. Doppler ultrasound for pulses, liquid nitrogen, angle-poised lamp, fluorescein lamp, step for the couch, autoclave, vaccine fridge, things that you have principally. So that was it, we’re not having a swimming pool out the back for our benefit. I don’t think my senior partner would wear that at all.\textsuperscript{180}

\textsuperscript{176} From GPP interview number 07.
\textsuperscript{177} From GPP interview numbers 18, 10, 09, 05.
\textsuperscript{178} From GPP interview number 21.
\textsuperscript{179} From GPP interview number 21.
\textsuperscript{180} From GPP interview number 04.
Conversely, other partnerships exhibited a tradition of concern that a greater emphasis on technology might have devalued the patient-centred art of medicine.

Colin R: And I was doing a lady’s tummy one day and the baby spoke to me. I don’t know who got the biggest fright, the mother or me. In thinking about it, presumably we picked up a taxi who happened to be on the radio at the time I switched on. But it was [sighs] there was really honestly voices came out this damn thing.

*I mean I switched on the Doppler, which is just a wee ultrasound thing, and there was voices came out of it. So the only thing we could think of was it was a taxi or a police car or somebody on the radio had just at the right time. We picked up this — as I say the mother nearly fair came off the blinking couch.*

There may, indeed, be some evidence that GPs with positive attitudes towards caring for mentally ill patients displayed less enthusiasm in adopting new technology, while those who were most keen on technical innovation were not as comfortable in treating mental illness.

One of the most significant changes in the way GPs understand disease has been in the development of a greater emphasis on preventive medicine and, more recently, on health promotion.

Fiona T: No I don’t think health promotion... was an issue when I started [in the early 1980s] [laughs]. So that’s a big new area and it’s something that we’re currently looking at.

For some of Paisley’s doctors, however, early enthusiasm for population-based initiatives had given way to cynicism and anxiety that some screening programmes may be ineffective or intrusive.

Christopher J: I remember health screening, even when the contract came out in 1990 you know, everybody had to have a three-yearly health check and some people believed it was a good idea and did these things, there was no evidence for it at all, eventually it just got dumped, but we just didn’t do it at all.

... It’s all part of this health police stuff and health promotion and doctors controlling your life as to how you should behave. We’ll all be wearing little black uniforms, little HP insignia and peaked caps and we’ll be going down the street taking people’s cholesterol in the street and if it’s over 6.5 put them in jail or fining them for having high cholesterol or whatever.

As in Bosanquet and Leese’s study, Paisley’s younger GPs expressed a greater interest in new developments. Older practitioners can also often recall that they displayed a greater commitment to change at earlier points in their careers — to the improvement of record keeping systems, for instance. Doctors who were in mid-career and beyond also argued, however, that their conservatism was born of bitter experience. They cited the difficulties of managing patients dependent on sedatives, coupled with the impacts of drug scares, most notably thalidomide.
11: Teaching and training

Graham Smith

The medico-political history of general practice education has been explored in some detail. This includes the years between the formation of the NHS and the Family Doctors’ Charter. These years are identified as a time of decline, before the College of General Practitioners’ strategic decision to concentrate on training took effect and before the emergence of undergraduate teaching. In Scotland, general practice education has had a particular historical significance. The earliest experiment in joint training, linking hospital and general practice, was pioneered in Inverness in 1952. The first department of general practice was founded in a dispensary practice some four years earlier in Edinburgh, with the first chair appointed in 1963. England only slowly followed suit.

The Edinburgh department was to provide an important resource for the Scottish Council of the College of General Practitioners, and it was members of the Scottish Council whose efforts were instrumental in the introduction of a membership examination.

By the late 1960s, the voluntary trainee practitioner scheme, established with the formation of the NHS, was on the verge of collapse, with trainees complaining of the lack of teaching and their exploitation as ‘an extra pair of hands’. Later developments were much more successful. So, in contrast, the introduction of regional advisers in 1972 and mandatory vocational training nine years later not only strengthened postgraduate education, but also ensured its separate and rapid development. While it was also a time of growth in the numbers of departments of general practice, postgraduate education proved more significant to rank-and-file practitioners.

The interviews with the Paisley GPs suggest that even prior to the voluntary scheme there were informal arrangements, which involved teaching hospitals and local practices providing work experience for students. More importantly, while it is significant that the Local Medical Committees (LMCs) agreed to hand over responsibility for trainers to the universities in 1973, the oral histories also provide evidence of a greater degree of continuity than has so far been acknowledged.

The relationship between LMCs and local College activists in Paisley was described in contemporary committee minutes relating to educational matters, and in subsequent recollections, as in the main constructive. And despite initial friction, agreements were amicably reached on important issues. So, for example, in the early 1970s, Douglas H (who was shortly to become a Deputy Regional Advisor) was involved in a series of postgraduate education meetings in the West of Scotland.

Douglas H: There was a fair bit of niggle between the College and the LMC … The LMC were reluctant to allow some other body to come up and say this is what should be done, although they had no axe to grind in that they didn’t have anything to do with training GPs, just appointing them. They had to be persuaded …

I think the motivation really was to see general practice get onto a higher plane than it was on … If you are producing better

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189 Rivett G. From cradle to grave: fifty years of the NHS. London: King’s Fund, 1998.

190 Lawson JAR. The Royal College of General Practitioners: its growth and influence over the past 40 years. Br J Gen Pract 1992; 42: 210-211.

trained doctors across the board it will raise the standard.\textsuperscript{192}

This process is said by the GPs to have been assisted in the west of Scotland by a number of key LMC activists holding College memberships. The common aim to ‘raise the standard’ had another meaning as Gerard D alludes to:

\textit{In those days [c. 1974] it was not uncommon for GPs to be talked down to … and I felt we should get involved in teaching … And eventually folk would come to Paisley to do their house jobs to get on to the Paisley scheme but it was the general practice side of it that was the bit that actually attracted them and the bit that was good … I eventually became [c. 1985] the Associate Adviser for the Renfrew District Scheme …}\textsuperscript{193}

The interviews uncovered the ways in which education was a significant mechanism in the transmission of new ideas, techniques, values, and attitudes between generations of doctors. Differences were found between the official policy and what was being taught at a practice level. Even after assistantships were replaced by vocational training, apprenticeship in its broadest sense continued. The interviews suggest that knowledge in academic general practice was not based on clinical and other technical skills alone. Rather, other issues, such as power and authority in education,\textsuperscript{194} power in practice (including partnership structures), and the moral environment in which educators and students operated were also often referred to in the practitioners’ narratives.

The early trainers believed that inculcating values and attributes was at least as important as passing on skills. Like others, Charles Mc believed that undergraduate and postgraduate hospital education would teach clinical skills, whereas his job was to teach the ‘human element’.\textsuperscript{195} Early trainees appreciated such teaching.

\textit{Damian S: Stuff they can’t teach you in a book: how to talk to people; how to listen to people; what to do with this condition … It was like an apprenticeship in general practice}\textsuperscript{196}.

For those who entered practice in the late 1970s and after, postgraduate education in general practice was often described as the most useful component of training.

\textit{David R: The hospital training was relatively much less useful than the GP training … Okay, there were a few things that I picked up through working in the hospital that I might not have been able to pick up otherwise, but it’s a very inefficient way of learning things about work in general practice.}\textsuperscript{197}

But members of the same cohort were also more likely to question their training. For example, while home visiting was justified at some length by trainers, the registrars were unconvinced and would often dismiss return visits, in particular, as ‘social service’. The same GPs also began to question the absence of training related to the financial running of practices.

\textit{Brian R: He [the trainer] was never particularly critical of me, but as soon as I expressed an interest in the business side of general practice he did say that, “The business aspect is probably the negative aspect that’s crept in”.}\textsuperscript{198}

Others in the same generation were identifying problems in learning experientially with a single trainer.

\textit{Eleanor H: If you work with a general practitioner, that becomes your template. That is what you think is the norm … My trainer was nice, but it was learn by example. I particularly remember one…}\textsuperscript{199}

\textsuperscript{192} From GPP interview number 16.

\textsuperscript{193} From GPP interview number 27. According to Douglas H, the scheme was established in 1978, five or so years after the Southern General Scheme that he had worked on in the early 1970s.


\textsuperscript{195} From GPP interview number 10.

\textsuperscript{196} From GPP interview number 19. GPP 15 makes a similar point

\textsuperscript{197} From GPP interview number 06.

\textsuperscript{198} From GPP interview number 05.
experience [c. 1978] when I didn’t know what to do on a house visit and he said, “Och, send him in”. And that was not the level of advice I was looking for; I could have made that decision myself ... I wanted him to come and discuss … I think he was just too busy to offer me the kind of support that I was looking for … as I say the first six months I don’t think I got huge amounts from my experience of general practice … But we did have a half-day release programme and I got a lot from that. That was good and well organised ... a good experience and I enjoyed that and it put you in touch with all the registrars in the area and we shared experiences.199

Fiona T: I was very unsure of myself and I think he [the trainer] sensed that and so he thought it would be better if I just kept following him around [laughing]. I had got into the spiral of despair that this was all I was going to do [laughing]. He was marvellous from the point of view of learning by example. Sort of an old apprentice style ... And I learned lots ... very many wise things from him ... I just remember him asking obscure questions and sort of sniggering at me, because I didn’t know the answers ... it didn’t work with me — humiliation doesn’t ... it just made me feel abysmally stupid and [laughing] I just avoided him for the next few days, so I wouldn’t be asked anything else ... That sounds very critical and I am not, because I think that was the way training was. And I think it has changed and we’re looking at it in a different way now. And I think it serves me very well and if I learnt nothing else directly from him then those were great things to take forward.200

The character of the early developments in Scotland also encouraged the emergence of distinctive organisational structures. These included the formation of the Scottish Council for Postgraduate Medical Education (1970) as a non-statutory body, fulfilling the co-ordinating role recommended by Todd Report (1968). Increasingly, there were attempts to introduce more formal teaching along with the evaluation of those practitioners, and their practices, who were aiming to achieve training status. Paisley’s family doctors have often felt themselves part of innovative developments in general practice education, especially given the West of Scotland’s lead in championing standard-setting, including A4 record keeping, and more recently in new methods of assessment that test minimum competence.201

As postgraduate education developed, including the introduction of paid Associate Advisers in the mid-1980s, some of the GPs in Paisley reported that they had begun to feel that training had become an exercise in ‘empire building’ — a phrase used by a number of practitioners.

And in the last two decades of the twentieth century, training increasingly used and more directly used to raise standards.

Gerard D: And if you came to join my practice or hoped to be a trainee in my practice, I was dictatorial as well. I would say, “If you come here you will sit the College Exam.” … But I think things like exams, like audit and all the rest of the things, like videoing, like formative, summative assessment, it’s put more and more pressure on the trainees … So it’s really a fairly stressful period for them now.202

David D: We’re quite disappointed at the way aspects of the requirements for being a training practice have gone. They’ve really made it very difficult for practices like ourselves to live up to these requirements … When I came to the practice it was still quite worthwhile to the practice in financial terms to have a trainee and there was a significant service element to what the trainee did at that time. Trainees did out-of-

199 From GPP interview number 12.
200 From GPP interview number 28.
202 From GPP interview number 27.
hours work ... And, I'd certainly have major misgivings about trainees or registrars completing a year and not having had the realistic exposure to what a principal does ... In the last four or five years I'd say the income from [laughs] being an accredited training practice was really of no interest to us. It was all about the workload that it had created for us and ultimately we just felt that we couldn't sustain that.  

Training continues to be associated with professional status in relation to hospital medicine, but it also has become a mark of status within general practice itself.  

Colin R: So it's sort of telling people that we are pretty good. We're maybe not the best and it's not saying that non-training practices don't do good jobs, but at least every three years we get tested and we're achieving a standard. It is a status thing ... So we became trainers I think about '84, '85 I think it was our first trainee came through. And of course in the old premises it was difficult. In the old premises no matter how good we were we wouldn't be a training practice because we just physically didn't have the space.  

The cyclical histories of practices, including changes in partnership and other team members, have meant that practices cannot always meet the demands made by postgraduate education. Having a turnover of training practices is a way of spreading good practice, although the interviews suggest that the doctors who serve the most deprived sections of Paisley’s population are much less likely to become trainers. Service GPs have long recognised the educative value of having students or trainees around their practices. However, there were clearly stresses and strains emerging in the 1980s between the culture of everyday practice, including the importance older GPs found in experiential learning and knowledge and the attempts to develop new methods of training that were being developed by a postgraduate department clearly aiming to improve training provision and theoretical understanding. Evidence of such tension reinforces suggestions that despite the considerable success of academic general practice, the identity of the discipline remained problematic.

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203 From GPP interview number 09.  
204 From GPP interview number 22.  
205 See for example interview numbers GPP 02 and GPP 30.  
206 See 5: Gender and narratives of profession.  
12. Reflections and the history of disappointments

Graham Smith

Hector M: I enjoyed it so much. The joys and sorrows of it: confinements; getting people better; listening to their problems [pause]. And I hope I didn’t make many mistakes. Of course I must have made some mistakes … In a way I regretted [retiring], because I enjoyed the work, but I didn’t regret not having to go out at night.

Robert E: I had been in practice from ’52 till ’89 … Looking at them nowadays, with all their gadgets and computers and things, I am glad I am out of it. But … if I was starting again I wouldn’t want to do anything else. 208

At the end of their interviews, the doctors in the Paisley project were asked to reflect on their careers and many talked about disappointments. For example, among those who entered practice before the mid-1960s there was a belief that becoming a GP could still be perceived more than three decades later as evidence of their failure to enter hospital medicine. 209 While they worried that, historically, GPs had been thought of as inferior to hospital doctors, these older practitioners counterposed this concern with recollections of the pleasure they had derived from delivering patient care. Their disappointment was with the lack of status afforded to general practice within medicine, rather than with either their patients or general practice itself.

However, most of the oldest GPs expressed their enjoyment of being a family doctor.

Douglas H: My year as an intern or a resident was a highlight year, because it was full of experience, which was available at that time … My army career was a highlight … And then probably we would move to the introduction of the Charter and being able to acquire better premises, better equipment, better assistance and whatnot — that was a highlight … It was obvious we were seeing practice becoming more what you imagine it to be … 210

There was a sense of frustration among those who joined practices from the late 1960s onwards that general practice had not met their expectations. They had directly experienced the improvements that had flowed from the 1966 contract, but were then subject to a series of government interventions that were widely believed to be unhelpful to GPs. From their perspectives, the promises of the Charter had given way to inadequate political fixes, external surveillance, and increased paperwork. One doctor described these developments as the ‘crap’ that should have been ‘cut out’. 211

Donald W: In 1990 I kind of thought … just jack it all in [laughs] … All sorts of nonsense was thrust upon you … The idea that because you were financially responsible you might adjust what you were doing! I mean you do blood tests on the clinical need not on how much money you are spending … There isn’t any doubt that there’s a vast amount of money spent on the health

208 From GPP interview number 13 and From GPP interview number 07.

209 Younger GPs were much less likely to believe this. See 6: Beyond the practice.

210 From GPP interview number 16.

211 From GPP interview number 22.
service, probably inappropriately, in various ways like carpeting all sorts of fancy offices. 212

Unlike the oldest generation, younger GPs were more likely to recall their lives as a ‘whole chunk’ 213 and were less likely to separate what they saw as the private from the public, including family from work. While older retired practitioners might have questioned the relevance of questions about their family lives in the interviews, younger doctors tended to reflect on the ways in which their work impacted on their lives outside practice, as well as the ways in which personal experiences shaped their approach to medical practice.

Eleanor H: I mean there are some days when you come back and you are absolutely drained. I used the term ‘cared out’, because you have listen to so many people’s problems during the day. You know I can remember coming back and just wanting to have an hour’s peace and quiet and you know the children suffered … And you had to very consciously switch off and make time for them. 214

This was particularly evident in the recollections of the women who were still working as GPs at the time of the interviews. They believed that they had brought a range of useful personal life experiences into practice, including motherhood and caring for older relatives. Their working lives often seemed much more complex than their male counterparts. Attempts to meet the commitments inherent in family life were often undermined by the ways in which practices were organised.

Linda F: Maybe I take responsibility to my patients far too seriously. I’d take that on board and I’d accept that. But litigation is around the corner all the time … My mother died about four years ago and I thought, ‘What am I doing?’ I wasn’t really enjoying working very much. There were difficulties in the partnership … About a year and half ago I was considering leaving and getting a job elsewhere … [But] it has taken thirteen years now to remember lots of things, to have it in this filing cabinet that’s in my brain somewhere … you know the family relationships … I think we have the kind of practice where a lot of our patients regard us as friends as well as doctors.

Carol S: I wouldn’t want my daughter to do what I have done, because there hasn’t been time for things that I would have liked to have done for myself. So the priority was family and work and there was no other time, no other time … I will be 55 and I won’t be here … Well, we’re going sailing. We will sail round the world slowly [laughs]. 215

A recurring theme amongst the oral evidence of these doctors, like the testimony of their older colleagues, was that successive governments had failed to improve general practice and had imposed policies that were harmful to the profession.

And in common with their older practice partners, younger men and women believed that caring for patients and their families had made their work in practice worthwhile.

Stewart McC: I am still quite happy working as a GP … The thing I’ve liked about it is just being in contact with people and getting to know them and being able to do things for them and also being appreciated by lots of people.

212 From GPP interview numbers 29 and 25.
213 From GPP interview number 15.
214 From GPP interview number 12.
215 From GPP interview numbers 18 and 08.
Andrew K: General practice is a reflection of life. You are so aware of life and death. … You see people growing older and you see what life does to them …

Fiona T: I've been twenty years a doctor and I can't think of anything else I'd rather do. I haven't lost my enthusiasm for it. I still can say to students, 'Yes you've made the right choice … yes, it will be hard work, it will be frustrating …' It saddens me to read about … lack of morale … There is nothing I'd rather do.

John H: What we all went through prior to the split up of the last practice was a dreadful low — it was terrible and affected me as a person, took a couple of years to get over. … I still enjoy the job I'm doing. There are times when you are under stress, times when you are frustrated. But they are far outweighed by the benefits, the good points.

Gavin W: There have been good bits and bad bits … I still think that essentially I've done the right thing with my life. It's not been without fret and worry at times, fear sometimes, pleasure, challenge … After virtually thirty years of night work I've had enough and I thought I don't want to go to the police station to see if this junkie is fit to take his prescribed methadone which he says he has to have at three o'clock in the bloody morning … There are times when I break out in a cold sweat and think, 'Oh my God, what have I done?' … Hopefully you go back, look at it, and you've been OK … We're all capable of setting off down the wrong road for quite simple reasons. It might be because of something we did or saw yesterday, a different patient with some other problem, or maybe because your wife's car has broken down and you've had to do the school run and you've come in here all hot and hassled. It is a job that can carry an immense lot of pressure.

Almost all of those who reflected on their working lives also recognised the stresses involved in being both professional and business minded. Family doctors have historically been expected to embrace entrepreneurial and professional ideals at the same time. This is in spite of the tension that exists between the entrepreneurial model, which 'called for as little state interference as possible', and the professional model, which 'looked to the state as the ultimate guarantor of professional status'. With government policies balanced between these two ideals for a large part of the first 30 years of the NHS, it is unsurprising that most GPs said that they had felt that general practice often lacked direction.

Jennifer W: I just don't like the way general practice is going. You have got to be a businessperson, businessman … Starting again? I would swither hard [be hesitant] … I wouldn't have encouraged my children to go into medicine. The country can't afford it and never will be able to afford the NHS. No I wouldn't go into general practice — definitely not … I mean lots of happy memories … I did enjoy it.

In the 1980s there was a change in 'the master conflict of professional society' between the public and private sectors over taxation and government spending. The 'integrity of the professional' began to be challenged and the service ethos across the public sector undermined. During the same decade there were rising expectations and demands from patients and politicians. There was also a growing 'intolerance of risk'. Then, in the next decade, the 1990 Contract resulted in raising both hopes among the more entrepreneurial-minded GPs, and fears among those who were less persuaded by market rhetoric. This was compounded by the rise of the new health consumer, which brought new uncertainties.

Robert B: When I was a boy I didn't think there were any poor GPs … It was a shock to realise that you had to live to a budget …

216 From GPP interview numbers 30, 25, 28, 21, and 17.


It could be an absolutely marvellous job … and the answer lies somewhere between adequate funding and a satisfactory level of consumer control … There has to be a degree of public responsibility … but it would cost votes.221

The youngest of Paisley’s GPs seemed to have faced the worst of all possible worlds. Not only did they believe that professional status was under threat, but those who had harboured entrepreneurial dreams in the early 1990s were also disillusioned. Unhappiness with practice was frequently expressed by the youngest GPs, although their evidence also suggests that satisfaction continued to be derived from patient care.

Brian R: I find it a bit more than irksome that my friends who are lawyers and accountants earn double what I earn, three times what I earn. I find that irksome and yet talking to a lawyer friend of mine who is a corporate lawyer, a very, very wealthy chap, he says that he would like to do something a bit more public sector-orientated …

I also like the idea of general practice being a business … I just think it gives you more commitment to what’s going on in your practice … I think I do see myself staying here in this practice, but not forever … The best thing’s making folk better. Coming up with the right diagnosis and explaining it to patients in a way that they know that they are going to get better …222

Three of the younger male GPs left practice within between April 2001 and May 2003. One joined NHS 24, another left to work for a pharmaceutical company, and a third emigrated, completely leaving medicine.223 Yet, replying to the question of whether he would remain in practice one said, 'I'm certainly not looking to change'.224

Two of these doctors had expressed a strong commitment to primary care.

Disappointment itself has changed. Ian Craib, the sociologist and psychotherapist, wrote about the need to tolerate and make use of our inner turmoil, the uncertainties, contradictions and paradoxical situations we find ourselves in, so that we can improve ourselves as citizens of an imperfect world. He also pointed out that many of us lack an appreciation of the value of disappointment.

The important thing about the society outside our heads is that while it provides us with all sorts of opportunities, it must also provide us with disappointments … Changes in society can change my life without my having any understanding of how those changes come about.225

I would like to thank the Paisley Docs for the time and energy they expended in trying to improve our understanding of how changes the lived through came about.

221 From GPP interview number 23.
222 From GPP interview number 05.
223 At least one other member of Paisley’s youngest generation who had not been interviewed had also left general practice.
224 From GPP interview number 04.
<table>
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<th>University graduated from</th>
<th>Year qualified</th>
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GPP 11 withdrew from project.
GPP 14 (a and b) was a group interview with two partners in the same practice.
GPP 26 is an interview with a general physician, born 1917, who worked at the local hospital.
NR = Not reported; N/A = Not applicable