

# JAMES MACKENZIE LECTURE

## Common sense and uncommon sensibility\*

JOHN FRY, OBE, MD, FRCS, FRCP

General Practitioner, Beckenham, Kent

The 24th James Mackenzie Lecture was delivered at the Imperial College, London, on 20 November 1976.



WE, as general practitioners, are truly fortunate in the opportunities that our work has given us. Yet, in our daily toils, we scarcely have time to pause and reflect on our good fortune and on our opportunities—many of which are sadly missed.

I stand before you today to offer a thanksgiving for some 30 years of joys and sorrows, excitement and stimulus, successes and failures in my practice, and to share some of my clinical experiences and philosophies with you.

Working in general practice broadens the mind and humbles the soul. It is very different from the sheltered world of hospital practice. It is as though we, in general practice, work in the natural habitat of the jungle, seeking and stalking our prey in its own environment, whereas our hospital colleagues have to function behind the bars of a zoo, dealing with patients and diseases in highly artificial situations. We general practitioners also share with the naturalist the chance to observe and study changes in our patients and their disorders over many years, as though we were watching a continuous moving picture show. However, our hospital colleagues are not so fortunate; they have to peer at snapshots of patients and diseases as they present at the particular moment of referral.

\*Published by kind permission of the Editor of the *Practitioner*.

© Journal of the Royal College of General Practitioners, 1977, 27, 9-17.

### Acknowledgements

It is customary to acknowledge and give thanks at the end of a paper or lecture. I want to give thanks now. First, to Sir James Mackenzie. I was an infant when Sir James died, but I first remember his name on my father's bookshelves. My father, a general practitioner, who taught me the rudiments of careful record-keeping, observation, and service to patients, was proud to have Sir James' books and he used to quote him as a shining example of what can be achieved from a general practice by dint of relatively simple applied research.

This was my introduction to general practice research. I owe thanks both to my father and to Sir James Mackenzie. This is my third 'Mackenzie' honour. In 1966 I received the James Mackenzie Prize of this College, then in 1969 I received the James Mackenzie Medal of the Royal College of Physicians of Edinburgh, and now, in 1976, I have the honour of delivering the lecture.

Another major influence on my medical development was John Ryle, Physician of Guy's Hospital and author of the *Natural History of Disease*. It was he who first made me aware of the importance of long-term observation in the course and outcome of disease.

I have much to thank this College for as a meeting place for like minds such as Ian Watson, Robin Pinsent, Donald Crombie, Tev Eimerl, Peter Walford, Clifford Kay, and others on the earliest research committees who dusted my brains and filled them with new ideas. More recently, Pat Byrne, John Lawson, Donald Irvine, and James McCormick have done much to curb my over-enthusiasm.

I have to thank Gordon McLachlan and my fellow trustees at the Nuffield Provincial Hospitals Trust over the past 20 years for leading me into the fascinating labyrinths of operational studies of health care; Sir George Godber and Lord Cohen for encouraging me in my early years, and Abraham Marcus at *Update* for giving me the opportunity to develop my interests in medical publishing and writing.

Above all, I owe thanks to my patients for the clinical opportunities to observe them and their illnesses, my partner, John Dillane, and our practice staff.

## General practice as a special field

On re-reading Sir James Mackenzie's books, I find it remarkable how he anticipated current views and trends and how accurately he defined some of the special features and opportunities of general practice. He was half a century ahead of his time.

Writing of his time in his practice at Burnley, he observed how useless the standard textbooks were for his work as a general practitioner: he looked on general practice as a specialty in its own right with its own core of clinical knowledge, and he stressed repeatedly the importance of early symptoms and the knowledge of the natural course and outcome of the common diseases.

He demonstrated the scope of research in general practice using simple methods and tools and he criticized, even then, the misuse of pseudoscientific concepts that have little practical application in everyday medical care.

Let me now develop and demonstrate to you my beliefs in the growing importance of general practice, not only as an essential level of care in all health systems, but as a source of knowledge which, if applied with common sense and uncommon sensibility, will lead to better, more economic, more comfortable, and less dangerous care for our patients.

## What is general practice?

What is this special field of care and what goes on within it? Within every system of health care there has to be a primary level of medical care. We call it 'general practice' and we are its 'practitioners'. But it exists in some form or other in all systems (Figure 1). In the USA it may be the specialoid paediatrician, internist, or psychiatrist who provides the primary care. In the USSR it may be the allocated staff at the local polyclinic, in China the barefoot doctor, or in Africa the medical assistant. Wherever we look someone has to act as a primary health care worker, and the roles and functions are similar. The huge pyramid of health care services

has to have a sound foundation. Therefore, it makes common and economic sense to support and encourage good general practice.

## Accessibility

A look at our roles gives us clues to the special opportunities for study and research. As general practitioners we have to be readily available and accessible to our patients. I remember that my father, who was in single-handed practice, was on duty in the 1930s and 1940s seven days a week and even held regular surgeries on Saturdays and Sundays. He always seemed to enjoy his work and rarely grumbled. Now though, with deputizing services, practice rotas, appointment systems, surgeries ending at 17.00 or 18.00 hours, and secretaries and receptionists protecting us from our patients, we seem to grumble much more. There must be a moral in this. Too much work is not good for us, but perhaps too little work is even worse!

## First-contact care

We provide first-contact care. Our patients come with the earliest symptoms and we study their significance and importance.

## Small and static populations

Our work is involved with relatively small and static practice populations of around 2,500 patients, and we are able to come to know well the personal, family, social and environmental factors related to diseases and their outcome.

The content of disease in general practice is that which will occur in a population of 2,500. Common diseases will occur frequently, and rare ones rarely occur. The emphasis will be on the minor and the chronic, rather than the acute and dramatic.

## Long-term continuing care

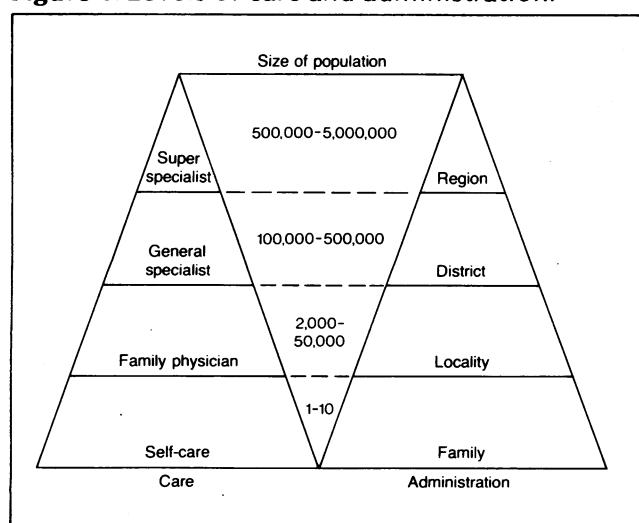
We provide long-term and continuing care, and we can observe, record, and analyze the course and outcome of patients with the more chronic disorders.

These are the features of my own and every other general practice. For nearly 30 years I have used simple and cheap methods of recording data on my patients and I offer you some of my findings.

## Who comes for advice?

The interface between the patient and the doctor is fascinating, and a study of consultation patterns sheds some light on a subject of much greater depth. Why does a patient consult his family doctor in the first place? There is no simple answer, since it depends not only on the presenting symptom or sign but on that patient's attitudes, beliefs, wants, expectations and upbringing, and on local and national customs and social requirements.

**Figure 1. Levels of care and administration.**



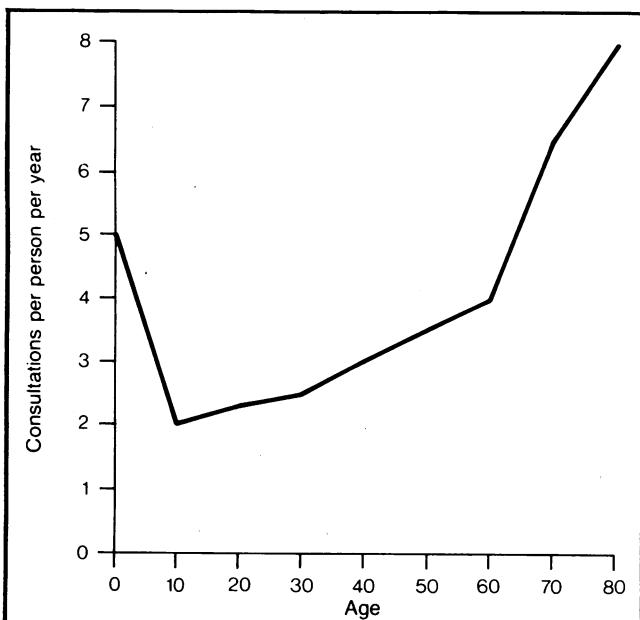


Figure 2. Consultation rates by age distribution.

The consultation rates are highest in the elderly and in children (Figure 2). This is to be expected because that is when we tend to suffer most from illness.

In general, women consult more than men. There are regional differences (RCGP, 1973), and the highest consultation rates are reported consistently from Scotland and the mining areas; but there is no definite relationship between these high consultation rates and morbidity. It is much more likely that consultation rates (or workload) are in the hands of the practitioner himself. The Second Morbidity Survey (OPCS and RCGP, 1974) gives the consulting rates for 59 practices. The mean consulting rate was three consultations per person per year. There were no significant differences between urban (2.9) and rural (3.2) practices, or between regions. However, there were marked differences between individual practices, often in the same area, ranging from 1.8 to 4.6 consultations per person per year in rural areas, and from 1.9 to 5.8 in urban areas.

The consulting rates also vary among our patients. We all know only too well the 'familiar faces' in our consulting rooms. These tend to suffer no more from major illnesses than do the unfamiliar. They seem to like to come and see us.

Some years ago we carried out a survey in our practice comparing the non-attenders with the frequent attenders (Kessel and Shepherd, 1965). We discovered that 100 patients had not consulted us for ten years or more. This may sound remarkable, but it is true. They were subsequently visited by social researchers and questioned. In brief, the non-attenders suffered no less from minor illnesses than the frequent attenders, they merely dealt with the illnesses themselves. The main difference between the two groups was that the non-attenders were more self-reliant and had far fewer expectations of the medical profession.

### How much work?

The annual consultation rates per person are a crude measure of work done in general practice, but over a period of several years they can show trends in a practice. In our practice the workload has halved since I started (Figure 3).

The same trends have occurred in other practices. Probably we have all seen it. In *Present State and Future Needs* (RCGP, 1973) these trends are clear, and other reports and analyses show that these trends continue but with an eventual levelling off (RCGP, 1977). In our practice we have an annual patient consulting rate of two; although there were practices with lower rates in the Second Morbidity Survey (1974).

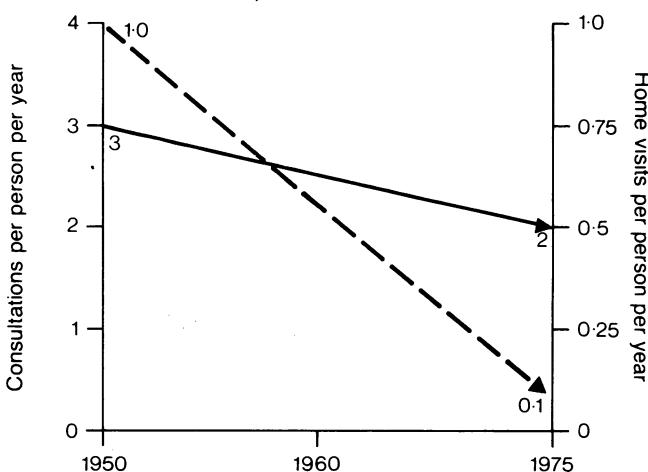
These figures are not cold statistics. They raise important and fundamental questions. If some practices can reduce their workload to almost half, or even a third of others, and at the same time provide satisfactory care, as shown by Marsh and Kaim-Caudle (1976), then why do other practices continue to have high workloads? A more important issue is that if the low-work practices are providing good care then should we not be thinking in terms of fewer general practitioners? We cannot all be expected to work at the same rate, but we must look further into the differences in work rates for the sake of the national economy.

### The content of general practice

What does the average general practitioner in an average-sized practice manage in a year? Table 1 shows the likely pattern. Approximately two-thirds of our clinical work is with minor, self-limiting diseases, one quarter with chronic disorders, and one-tenth with life-threatening diseases.

Such a pattern is inevitable. It may appear rather undramatic and undemanding, but it is the universal picture of primary medical care. The common respiratory

Figure 3. Annual consulting rates from 1950 to 1975. (Consultations – continuous line. Home visits – dotted line.)



**Table 1.** Content of general practice.

Disease	Patients consulting per year in a population of 2,500
<i>Minor illness</i>	
Upper respiratory infections	600
Anxiety depressions, personality problems	250
Skin infections, eczema, warts and urticaria	200
Diarrhoea, vomiting, dyspepsia, constipation	150
<i>Acute major illness</i>	
Acute bronchitis	60
Pneumonia	20
Myocardial infarction	8
Appendicitis	5
Strokes	5
Cancers	5
<i>Chronic illness</i>	
Chronic rheumatism	100
High blood pressure	50
Obesity	40
Chronic bronchitis	35
Chronic heart failure	30
Migraine	30
Asthma	25
Peptic ulcers	20
Epilepsy	10
Diabetes	10
Thyroid diseases	7
Parkinsonism	3
Multiple sclerosis	2
Chronic renal failure	under 1

tract infections are prevalent everywhere. They account for one third of our work in general practice. Emotional disorders account for 15 per cent, skin disorders 12 per cent, gastrointestinal disorders ten per cent, cardiovascular ten per cent, and rheumatic disorders eight per cent.

### General practice and hospital experience

Hodgkin (1973) showed graphically the differences in frequency of common diseases that occur in hospital and general practice (Table 2).

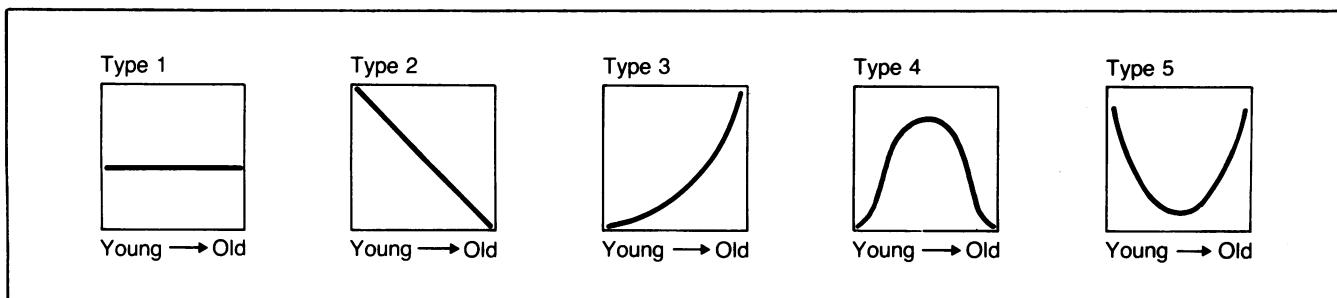
In whatever branch of medicine we practise there are some everyday matters that we accept as bread-and-butter work; only rarely does one encounter the jam. Thus to the neurosurgeon brain tumours are 'common'; the general practitioner experiences a new

diagnosis about every five years. To some general surgeons one or two breast removals a week are standard; to the general practitioner one or two new cases a year is the pattern. Similarly, for the local district hospital one or two appendicectomies a day is routine, whereas, to the general practitioner, five or six cases a year is more usual. So we could go on.

Hospital experience is important in a vocational preparation for general practice and it is important to remain up to date and familiar with hospital practice. The content of general practice confirms that it is a specialty in its own right with its own core of knowledge. This core comprises some disorders that are exclusive to general practice, such as high blood pressure, angina, strokes and anaemias, diabetes and thyroid diseases, rheumatism, peptic ulcers, migraine, and many others for which the majority of care is in general practice. It also includes situations such as the early stages of cancer and some rare and complex disorders where the role of the practitioner is to make an

**Table 2.** Approximate numbers of patients seen by a general practitioner and a hospital consultant in a year.

Disease	General practitioner	Consultant
<i>Medical</i>		
Acute bronchitis and pneumonia	80	100
High blood pressure	50	200
Asthma	25	50
Diabetes	10	200
Acute myocardial infarction	8	125
Strokes	5	120
New cancer of lung	2	50
<i>Surgical</i>		
Varicose veins	20	75
Hernia	7	150
Tonsillectomy and/or adenoidectomy	6	200
Acute appendicitis	5	100
Uterine fibroids	3	100
Gall bladder disease	1	30
Cancer of breast	1	25
Cancer of bowels	1	30
<i>Mixed</i>		
Upper respiratory infections	600	very few
Anxiety depression	250	100
Backache	50	300
Peptic ulcers	25	60
Thyroid diseases	7	25



**Figure 4. Patterns of natural history of diseases.**

early diagnosis and then to refer the patient to a consultant for a team-work approach to managing the condition at that stage.

### What happens and why

We have a special opportunity in general practice to observe the course and outcome of diseases. It is only in general practice that we are able to see the effects of time on people suffering from a variety of diseases. It is this naturalistic approach to the study of disease that has fascinated me over the years. Starting with the question of what happens eventually to patients with the more chronic diseases and why, I have kept simple but useful records of their progress and by indexing them under the specific diseases it is easy to analyze the natural history of each condition.

Five patterns of natural history can be recognized (Figure 4). They give a bird's-eye view of what is likely to happen to patients with various diseases, and this helps in their management.

#### Type 1

This is the once-and-always situation. If a leg is amputated it will never re-grow. Congenital disorders such as mongolism, coeliac disease, and phenylketonuria have to be accepted as incurable and unchangeable, and require long-term care.

#### Type 2

This group is exemplified by the catarrhal child syndrome, a condition most prevalent in early childhood which becomes progressively less frequent after the age of seven or eight. Similar childhood conditions that resolve naturally are umbilical herniae, strawberry naevi, knock-knees, bow-legs, and non-retractable foreskins.

#### Type 3

This is the pattern of disorders of ageing and degeneration. They increase in prevalence and severity from middle-age onwards and include the arthritides, coronary artery disease, high blood pressure, cancers, strokes and chronic bronchitis.

#### Type 4

This is a less appreciated but interesting and important group. The pattern tends to be an onset of disease in

early adult life, a period of activity of symptoms for 10 to 15 years, and then a spontaneous improvement. I have observed this in asthma, migraine, duodenal ulcer, hay fever, anxiety depression, the acute back syndrome, benign breast conditions, cervical erosion, piles, and acute urinary infections.

#### Type 5

This group is characterized by peak prevalence periods in childhood and old age. Conditions showing this pattern are the acute wheezy chests, constipation, herniae and hydroceles.

### Implications and applications

Research is useless unless it is for the benefit of both patients and doctors. Collecting and processing data is frustrating and wasteful unless it helps us to serve our patients better. It is not much use becoming excited about one's own annual consulting rate—whether it is less, more, or the same as someone else's—unless this leads to consideration of the reasons for the differences and the possible actions one might take to make one's own care more efficient.

It is relatively unimportant, although rather surprising, to discover that each year each general practitioner spends, on average, through prescriptions almost £15,000 of the country's money. Of course it is a vast amount of money and it is shameful that much of it goes on drugs of doubtful benefit. We must discover why all these expensive drugs are being prescribed and whether our patients' expectations and our own are being met. If our prescribing habits are wrong and wasteful then this should be demonstrated clearly to us, and some better ways of caring for our patients should be agreed on and applied. It is wrong for administrators, researchers, politicians, academics, and the public to criticize general practice prescribing. Let them take a turn at sitting in the hot seat of a consulting room faced with numerous patients with problems, knowing full well that many are incurable and unchangeable, but for which we are expected to do something. If we are to change prescribing habits, we will have to change public demands and expectations.

Let me turn now from this general review of general practice to quote some personal experiences. I want to

make a case for the better use of available data to produce better and more sensible care that is also more economic in the use of resources.

### Clinical and other experiences

From years of critical review and analysis of clinical data in my practice I have become a therapeutic sceptic, and before being persuaded to try some new and highly advertised product I want to know that it really is better and safer than the old. I have also become rather simplistic and pragmatic in my work, and I seek to use the simplest, cheapest, and most reliable techniques that meet my patients' needs and my own.

#### *High blood pressure*

I may be criticized but I am still far from convinced that all people suffering from the sphygmomanometric disorder that we refer to as 'high blood pressure' need life-long therapy with expensive and unpleasant antihypertensive drugs. To try and discover who really needed such therapy I compared the survival rates and life experiences of over 700 hypertensives in my practice (Fry, 1974a, 1975abc). I found that over half of all hypertensives were over the age of 60 when first diagnosed, that high blood pressure was a condition associated with ageing, and that it was twice as frequent in women as in men. I discovered that the outlook was worse in men than in women and that it was a much more serious condition in those under 60 than it was in those over 60. The observed mortality rates were not much greater than expected in the over 60s. Therefore while I am keen to diagnose early and treat high blood pressure in men under 60 and in some women, I am less than enthusiastic in treating over 60-year-olds with powerful antihypertensives.

This way I find that I need to treat only between a third and a quarter of my hypertensives selectively rather than blindly treating everybody with a raised blood pressure. The savings in drugs, time and effort are appreciable, and the benefits to my patients considerable, since they do not have to take unpleasant drugs for the rest of their lives.

#### *Myocardial infarction*

Long before the current views recommending that some patients with acute myocardial infarctions should be cared for at home, I did this and found that my results were as good for those kept at home as for those admitted to hospital. Also I have encouraged ambulation as soon as the patient felt like getting up, with no disasters (Fry, 1974b).

Like Mather *et al.* (1976) I agree that there is a definite place for treating the older and less severe cases of myocardial infarction at home. Following up some 300 patients with angina over the years I found it to be a much more benign condition than I had expected (Fry, 1976), and I wonder what types of cases are undergoing coronary artery by-pass procedures, popular in North

America. Hundreds and thousands of middle-aged and elderly people are being operated on each month in the USA and Canada for angina, many probably unnecessarily. I believe that it is fortunate that we have a National Health Service, that we have conservative heart surgeons who are busy with other conditions and are not paid in fees per operation, and that we have general practitioners who are prepared to act to protect their patients with angina from unproven and dangerous procedures.

#### *Duodenal ulcers*

Duodenal ulcers tend to improve with time and, given the chance, cease to trouble patients in most instances. Surgical treatment has been necessary in only 15 per cent of the 400 or so duodenal ulcers that I have managed. The rest have improved spontaneously over the years.

#### *Acute back syndrome*

I have been fascinated and perplexed by the swings of fashion in the treatment of the acute back syndrome over 30 years in practice. Traction to distract, the use of corsets and plaster of paris to fix the spine, manipulation to replace the slipped disc, surgery to remove it, rest and exercises to strengthen muscles, injections and massage and the application of heat to relieve symptoms, and of course various drugs for various hopeful reasons have all been used by the 'specialists'. I believe that, given time, 95 per cent will settle within weeks without dangerous and unpleasant therapy. We found that three-quarters improve considerably within a month and only about one in 500 needs surgery (Dillane *et al.*, 1966).

#### *Hay fever*

Hay fever tortures those who suffer from it, and those who do annually are almost all under the age of 40. What happens after this age? This intrigued me and on further study I found that the usual natural history was to start symptoms in childhood or teens, to suffer for 5 to 15 years and then for the symptoms to cease. Of course the victims need help during the seasonal periods, but it is most comforting to know that they will usually outgrow their troubles.

#### *Urinary infections*

The emphasis in hospital practice is on the end results of urinary infections, namely, chronic pyelonephritis and renal failure. In general practice I see about 500 people, almost all women, with acute urinary infections for every one case of chronic pyelonephritis or renal failure. I have found no relationship between frequent urinary infections and chronic renal failure and it is quite wrong to consider anything other than a safe outcome for these common urinary infections. However, where there are congenital or acquired structural defects in the urinary system, then the outlook is less good.

### *Common emotional disorders*

From analysis of the natural history of the common emotional disorders, the anxiety depressions, I have evolved a law of three-thirds. Within this group of disorders over the years one-third will suffer no further attacks after the initial one, one-third will suffer occasional subsequent attacks, and one-third will become chronic with persistent and recurring troubles. The challenge is to try and help those in the latter group, but in spite of my own endeavours and those of other colleagues, they continue to suffer and I have come to the conclusion that most of them are satisfied with this state and in a way resent attempts to cure.

### *Workload*

Reflecting on the trends of workload and patterns of work in general practice, I believe that we have more than enough doctors now in general practice, and possibly too many. I believe that we are training too many medical students for our needs (Fry, 1975d). There is a need for more positive and realistic studies into our real manpower requirements, enquiring into the ways in which doctors and nurses spend their time, and into the methods and techniques that they employ, as well as questioning whether much of the care given really is necessary.

### *Referrals*

My views on referrals to hospitals are similar to my views on workload. Our own referrals have been reduced over the years (Fry, 1971) because we have come to realize the limitations of specialist consultations and the fact that we can order most investigations on our patients ourselves. Our referral rates are about half the national rates. Does this mean that we refer too few patients to specialists or do others refer too many?

The 1975 hospital doctors' industrial action revealed some fascinating data which have not been publicized, for various reasons. Outpatient referrals and hospital work were reduced drastically, and the number of admissions was reduced. The volume of work in general practice did not increase and yet the local mortality rate went down. There are signs that elsewhere the experience was similar. Were more lives saved than lost because of the hospital doctors' inactivity?

### *Lessons from the past*

This is by way of being an interim report on my experiences in general practice. I hope I may be allowed to present a final report in another 20 years or so!

What can I pass on to my younger colleagues?

#### *1. Humility*

I have realized fully my own limitations and those of my profession, even in this age of modern science. We can still only 'cure sometimes, relieve often, comfort always and prevent hopefully'. I have sought to develop my

skills in the art of the possible and to create, above all, a realistic and commonsense approach to medical care that relates to the needs of the patient and to the resources that are available and effective.

#### *2. New and old*

The awareness that 'new' is not always 'best' and 'old' is not always 'bad'. Let me remind you of Sir Robert Hutchinson's prayers:

*From inability to leave well alone,  
From too much zeal for what is new and contempt for  
what is old,  
From putting knowledge before wisdom,  
Service before art, cleverness before common sense,  
From treating patients as cases,  
And, from making the care of a disease more grievous  
than its endurance,  
Good Lord deliver us!*

I should remind you that Sir Robert was a colleague of Sir James Mackenzie at the London Hospital, and I am sure that Sir James approved of those sentiments.

#### *3. Clarity and honesty*

There is a need for more clarity and honesty in stating our objectives. We must apply the art of the possible.

We should strive to be more precise and realistic in our understanding of: what is normal, what is curable, what is careable, what is treatable, and what is preventable.

It is all very well striving for the impossible in the care of our patients and acquiring the reputation of a practitioner who 'never gives up' (or of a surgeon who 'will always have a go'), but there has to come a point when we have to be brave and honest enough to say 'enough is enough' and that any more care will be unnecessary, unkind or uneconomic.

As protectors of our patients and as servants of the public we do have a responsibility to prevent and avoid needless care and therapy.

It is the appreciation and application of factors such as these that make medicine an art as well as a science, and it is the difficulty of measuring such imprecise yet important issues that makes the definition of 'quality' of care so frustratingly elusive.

#### *4. Own core of knowledge*

If we seek to have general practice, family medicine or primary medical care, or whatever we call our field, as a special branch of medicine, then it must develop its own core of knowledge that can be learnt and taught. This we are trying to achieve, but we must also strive much harder to prove ourselves as a scientific discipline, for unless we do so we shall not be allowed to enter the sanctums of the real academic. It is this lack of evidence of good scientific research that has created problems and ill feeling between family medicine and other specialties in the USA and, to a degree, in Britain.

We must strive even harder to demonstrate the research potentials and results. I shall not be happy until we achieve a Fellow of the Royal Society and a Nobel Prize.

### **Thoughts for the future**

Let me return now to more general issues that we will have to face in the future and let me direct these at some national bodies.

The Department of Health and Social Security should set national policies in health care and it should provide sound leadership. Personally, I have found it difficult to discern any positive national policies, and certainly I have not been inspired by its leadership.

Admittedly the DHSS has difficulties. It has to balance public and professional views, expectations, and demands. It has to make priority decisions and try to resolve an insoluble equation of wants, needs and resources, and it has to decide on allocation of funds (DHSS, 1976). However, in spite of such problems we should have stimulating and creative leadership from the DHSS. Such leadership would require better public relations than exist at present. Our present and future leaders at the DHSS, and in the NHS as a whole, must provide both the public and the profession with clear policies, targets, and reasons for actions based on reliable data. They will need help and co-operation from us and I am sure that we as a College will be ready to respond.

### *Academic departments of general practice*

There are now academic departments of general practice (or equivalent titles) at most medical schools. They are evolving teaching curricula and meeting long unfulfilled needs. In addition they must carry out and publish clinical research work based on sound scientific methods, which will be both practical and useful to fellow practitioners, and acceptable to their fellow academics. These are new departments, but even so, there is little evidence of clinical research in progress in many of them.

### *Postgraduate medical centres*

The 250 postgraduate medical centres have been active in organizing courses and meetings for general practitioners. Most have been individual exercises, and there have been few attempts to arrange an extended curriculum covering the needs of general practitioners. It is time that a constructive review of Section 63 courses was carried out.

As a specialty general practice will need continuing support from grant-giving bodies. We are grateful, as a college and as individuals, for the generous support that we have had from the DHSS, the Medical Research Council, the Nuffield Provincial Hospitals Trust and the King's Fund. We have also received, as a college, valuable assistance from the pharmaceutical industry in many ways, and without any conditions.

At this time there is need for a review of past support and of future needs. There will be need for much more support for research and experiments. A few examples will suffice. The first priority must go to clinical research along critical and evaluative lines. We need to know urgently what is useful and what is useless in the care that we are giving. This will require studies of the nature, course and outcome of common diseases, randomized controlled clinical trials, and examination of our methods of care.

### *Involvement of patients*

Next, we will need more data and information on the ways in which our practices are organized, and to take careful note of our patients' views. We have to examine how to get more patient involvement in the provision of primary care. This may be in the form of patients' committees or in co-operation with community health councils. The work of the primary health team is more than ready for review. The poor relationship between general practice and social worker services needs study and improvement. The future role of the general practitioner in hospitals, be they district or community hospitals, needs continual study.

There is an obvious need for planned support and development of research and experiment in primary care. The major grant-giving bodies should get together with representatives of the profession and the public to prepare a ten-year programme.

### *The College*

Finally, there is much for the College to do. The chief priorities in the immediate future must be education and research. Developments and improvements in education and training in general practice are being made all the time. What is necessary now is a critical and constructive assessment of the results and effects of such education and training, and decisions on which methods and topics are most appropriate.

In order to teach and to learn there has to be a constantly researched, evaluated and growing core of special knowledge in the field. Continual research, particularly on practical clinical subjects, has to go hand in hand with education. The College has to decide how it should be involved in continuing research, and which topics to choose. It may be that with so many academic departments the College's role in research will become less extensive and more intensive and selective.

I want to end with a final thank you to this great College of ours; a thank you to this professional body of men and women, supported by such loyal staff, which has done so much for British and world medicine in the past, and which has so much to do in the future.

### **Conclusions and summary**

Sir James Mackenzie would probably have been partially satisfied with the progress and development of general practice in the half-century since his death. He

would be happy to see the emergence of general practice as a special branch of medicine receiving increasing recognition and respect. He would be pleased with the College and its policies and achievements, but almost certainly irritated and frustrated over the lack of sound original clinical research from general practice, on the basis that he started and demonstrated this concept in his practice in Burnley a century ago.

General practice is a specialty. It has its own content, its own methods of diagnosis and treatment, and its own educational and special research requirements. Great progress has been made during the lifetime of the College, now almost 25-years-old, particularly in defining the content of general practice and in creating and developing systems and methods of vocational training and assessment through the MRCGP examination.

The next major challenge for us all is a clearer and sounder delineation and understanding of the core of scientific knowledge of clinical medicine, and operational methods of organization and practice.

The acquisition, demonstration, and teaching of such knowledge will demand much hard basic research, which is an essential ingredient of any scientific branch of medicine. It is wrong and unfair to expect undergraduates, vocational trainees, and lifelong graduate students—which we all are—to be taught by well-meaning teachers who have not researched, digested, and proven their own core of knowledge. No longer is it sufficient to base our teaching on reminiscences and anecdotes. Every specialty must create its own recognizable and acceptable collection of knowledge founded on stated hypotheses proven by research.

I see this collection of our own clinical and operational treasures that represent the scientific core of knowledge of our specialty as our next major goal and challenge. To harvest and gather our fruits we need help. We need the help of clinical and research colleagues in many other specialties and disciplines, and also we need the guidance and support of grant-giving bodies.

We have come far in the 50 years since Sir James Mackenzie died. We still have some distance to travel to meet his goals and hopes for general practice as a vital and essential branch of scientific medicine. There are no reasons why we should not reach them.

## References

- Department of Health and Social Security (1976). *Priorities for Health and Personal Social Services in England: a Consultative Document*. London: HMSO.
- Dillane, J. B., Fry, J. & Kalton, G. (1966). *British Medical Journal*, **2**, 82-84.
- Fry, J. (1971). *Lancet*, **ii**, 148.
- Fry, J. (1974a). *Lancet*, **ii**, 431-433.
- Fry, J. (1974b). *Common Diseases*. Lancaster: Medical and Technical Publishing.
- Fry, J. (1975a). *Journal of the Royal College of General Practitioners*, **25**, 481-486.
- Fry, J. (1975b). *Journal of the Royal College of General Practitioners*, **25**, 489-494.
- Fry, J. (1975c). *Update*, **10**, 1238-1243.
- Fry, J. (1975d). *Update*, **11**, 263-273.
- Fry, J. (1976). *Journal of the Royal College of General Practitioners*, **26**, 643-646.
- Hodgkin, K. (1973). *Towards Earlier Diagnosis*. Edinburgh: Churchill Livingstone.
- Kessell, N. & Shepherd, M. (1965). *Medical Care*, **3**, 6-10.
- Marsh, G. & Kaim-Caudle, P. (1976). *Team Care in General Practice*. London: Croom Helm.
- Mather, H. G., Morgan, D. C., Pearson, N. G., Read, K. L. Q., Shaw, D. B., Steed, G. R., Thorpe, M. G., Lawrence, C. J. & Riley, I. S. (1976). *British Medical Journal*, **1**, 925-929.
- Office of Population Censuses and Surveys and the Royal College of General Practitioners (1974). *Morbidity Statistics from General Practice. Second National Study 1970-71*. London: HMSO.
- Royal College of General Practitioners (1973). *Reports from General Practice No. 16: Present State and Future Needs of General Practice*. 3rd edition. London: Journal of the Royal College of General Practitioners.
- Royal College of General Practitioners (1977). *Present State and Future Needs of General Practice*, 4th edition (to be published).
- Ryle, J. A. (1948). *Natural History of Disease*. London: Oxford University Press.

## Future role of the pharmacist

As Professor Parish so accurately pointed out, the physician lacks motivation to learn about drugs because the whole of his education and training are focused upon diagnosis. Pharmacists never cease to be amazed at the casual attitude of many doctors towards the drugs that they prescribe, an attitude no doubt caused by a basic lack of understanding. It is true that physicians pick up a great deal of knowledge about drugs in the course of their careers, as, indeed, do pharmacists about clinical matters, but such accumulation of information is no substitute for formal learning. The success of MIMS hints at the desperate need of prescribers for a guide through the maze of modern drugs. Unfortunately, there are signs that it has been sometimes sadly mistaken for a tool of learning rather than recognized as a handbook for the learned.

There can be little doubt that the pharmacist could, if suitably trained, play a dominant role in the selection of drugs for the treatment of patients. Despite being without adequate clinical training, and also, perhaps, training in information science, many pharmacists are nevertheless attempting to discharge something of those duties at present; but the absence of formal training is a handicap. Many schools of pharmacy have made great efforts to widen the teaching syllabus to include clinical matters, but much remains to be done. In an already overcrowded syllabus, the scope for such developments are limited. It may be that the answer lies in an extended course. Such a prospect ought not to be rejected out of hand. Alternatively, it may be expedient to deal with the matter at the postgraduate stage.

## Reference

- The Pharmaceutical Journal* (1976). Editorial, **217**, 261-262.