

MORBIDITY SURVEY

THE pathologists of the nineteenth century, by their demonstration of bacteria and of the disordered cell structure and function following infection, are both to be praised for their lifesaving discoveries and blamed for attracting, concentrating, and almost monopolising the interest and attention of generations of doctors. They led us to believe that the whole of medicine was contained in the complex of specialties that existed in the mid-twentieth century, and that in reducing man to his ultimate molecules would lie the answer to all his health problems. It could almost be said that alignment of contemporary research has been determined by the bacteriology and later the virology of the infectious diseases and that, with each new order of magnification of the almost infinitesimally small, people's attention was diverted even further from the source of the material to be studied—man himself.

It was inevitable that sooner or later there would be a reaction and that there should be a second look at the natural history of disease. Could there not be other areas of no less importance than cellular pathology to be found—if they were sought? What did the quest involve? We had to go back to the days of the first observers, the practitioner naturalists who noted what they saw and from their observations defined with clarity the diseases we know today, as well as many that we see no longer. The field study of illness came into its own again—the first National Morbidity Survey of 1955–56 marked the turning point.

Much has been learned of morbidity survey methods and techniques since those days when the newborn College and the General Register Office planned a joint study with little more than an intuitive feeling that general practitioners could observe, think, and record. Walford and Eimerl, Kuenssberg and Kay, Watson and Williams, and the Research Unit team in Birmingham have devised, tested, publicised and introduced methods that have been accepted in many countries throughout the world. The morbidity survey has once again become an acceptable instrument of scientific discovery. The publication of the reports of the first survey was followed by national studies in Australia and in Holland. Practice studies were reported from Austria, Canada, Israel, and Norway, while the methods on which surveys can be effectively based are now spreading rapidly throughout the North American continent. Thus the stage was set for the second National Morbidity Survey to be carried out in England and Wales.

The second survey was planned by the College in collaboration with the Office of Population Censuses and Surveys—a reincarnation of the General Register Office—and the Department of Health and Social Security. These three bodies hoped from the beginning that a continuing study would result from their work. The second survey was launched in 1970. Once again the response by members of the College exceeded all expectations, and when the study began 53 practices—with three more in Northern Ireland—were participating. The practices taking part served a population of 350,000. The skills and services of the OPCS computer unit were available and funds were provided by the DHSS.

The report of the first year of the study covers much the same ground as that of the first. This was intended, so that direct comparisons can be made. The accuracy with which the primary records were made is, however, of a new high order following the

strict application of both external and internal checks. The range and scope of the tabulations has, however, been extended, to broaden the basis on which future comparisons may be made. The figures will speak for themselves, and the report will be in the hands and on the desks of epidemiologists and planners of health care in many countries.

Two of the more important results of the survey were the solution of the problem of the confidentiality of people's illnesses by separating identity and morbidity files in time and space, and the creation of a continuing study group whose work will go on for many years. There will be a second report about the work of the whole team and thereafter specific problems which can only be solved by considering large amounts of data will be looked at by the smaller group.

In the past morbidity surveys have been derided as mere exercises in head counting, but as methods of data acquisition and quality control have improved so also has the sophistication with which analyses can be interpreted. Working in the Research Unit in Birmingham, Kilpatrick has shown that the frequency of episodes of illness which the population of 350,000 brought to their doctors' attention in one year follows a geometric distribution, a fundamental observation which has many important implications in epidemiology and other fields. He has opened up the prospect that populations in need of medical care can be identified even in countries without National Health Services, as well as the degree to which there is shared professional care in such countries. Work which may put these hypotheses to the test is already going on in Canada.

Why are these new techniques so necessary now? Perhaps we are at the beginning of another reorientation of medical thinking comparable with that wrought on medicine by the pathologists and the clinicians. Understanding is growing that illness and maladaptation are not far apart, that morbidity represents failure on the part of biological mechanisms which should keep mankind in equilibrium with his environment.

Morbidity data from this survey, and others to follow, can be interpreted not in isolation but in terms of geography, nutrition, genetics, occupation and all the social influences that bear on man. The report of the second National Morbidity Survey marks just such a new beginning and the College should be grateful indeed to the many members, associates, and others whose contributions made this new beginning possible. Their help will still be needed. We have, with them, taken the first steps on a very long journey.

REFERENCES

- General Register Office (1958). Studies of medical and population subjects No. 14. Morbidity statistics from general practice. Vol. 1, General. London: H.M.S.O.