

THE FUTURE GENERAL PRACTITIONER:  
READING AND UNDERSTANDING

Sir,

Dr Eastwood's letter (November *Journal*) is important because he puts a view of clinical medicine in general practice which may be shared by others. He says "I think I have indicated that *The Future General Practitioner* raises serious questions for the College!" We agree. It was meant to do so. But it was not written as a statement of college policy nor as a syllabus for the college examination. (This he ultimately concedes.) It was written to provoke thought. We expected objections long since, on exactly the grounds that Dr Eastwood presents them.

His criticisms begin, ominously, on page 1 of our book, with that part of the job definition which states: "His diagnosis will be composed in physical, psychological and social terms." This, we are told, is unrealistic and over-ambitious. Why? Because "It is difficult enough in all conscience always to make a diagnosis in physical terms, even when supported by scientifically based information." This is the nub of his complaint and it informs the whole of his letter. Clinical medicine, as Dr Eastwood sees and values it, must be split into the science of physical "diagnosis" and the impressionism of psychosocial "assessment." The phenomena which constitute the experience of illness are reassembled by him in a hierarchy: scientific certainty; professional interest; human value. Body is split from mind, disease from behaviour, and sickness from society.

We believe that such a view of medicine is incompatible with the experience of clinicians in general practice. This was the most important point which we sought to convey in *The Future General Practitioner*. Dr Eastwood seems to argue that because the physical diagnosis is so difficult, other important variables, psychological and social, may be safely ignored. The scientific slackness of this sort of thinking simply will not do.

We are grateful to Dr Eastwood for indicating to us some passages which should have been more clearly and unambiguously expressed. But some of his misreadings are wilful rather than inevitable. For example, he points to the confusion in the reported figures for psychiatric morbidity in general practice. It was the *confusion* that we wished to describe. The work of Shepherd *et al*, (1966) which we quote in the book, reports just such large discrepancies in the reported incidence of psychiatric morbidity from general practice. The conclusion reached is that what have been reported are not clinical facts but iatrogenic fantasies. Without a nosology that includes the psychological and social components as well as the physical component of the human condition, doctors will translate illness into a psychiatric language which has the sound, though not the substance, of scientific validity. This is the point

that we make again in one of the two chapters on the consultation (p. 20) which Dr Eastwood so dislikes.

We come now to what Dr Eastwood calls "This wretched anecdote": the story of the young woman with thyrotoxicosis, trouble with her three-year old daughter, her elderly mother, and her husband's duodenal ulcer. In many ways the substance of this case is central to our argument. First let us admit that in the presentation of two pictures of the consultation (p. 26) we purposely did not make it clear at first that we were describing the same woman being seen by the same doctor at the same time. This does in fact become evident on the very next page, but Dr Eastwood's readings are selective and polemical. For example, he tells us that "This wretched anecdote . . . raises its ugly head again on p. 31 to poke fun at computer-assisted diagnosis." That is a strange reading of the relevant paragraph, which refers, *inter alia*, to the strengths and limitations of computer-aided diagnosis, giving as an example "thyrotoxicosis," for which computer programmes have already been written.

But Dr Eastwood is anxious to discover conflict: between the physical and the psychological, between diagnosis and assessment, and between the work of the general practitioner and the specialist physician, which the authors neither intended nor stated. He discovers it in his comments on the teaching about a 36-year old woman who has angina-like symptoms (p. 224). He says "The hospital teaching seemed to me to be entirely what the situation called for, while the general practitioner's teaching was simply irresponsible." The paragraph to which he refers explained that the hospital teacher was likely to concentrate on teaching about the differential diagnosis of myocardial infarction, and that the general-practitioner teacher might concentrate on the immediate and long-term management of overbreathing due to anxiety. That is enough for Dr Eastwood. He sees quite clearly the contrast between teaching which is "entirely what the situation called for" on the one hand, and "simply irresponsible" on the other.

It is a pity that he did not finish reading the paragraph. We said "Unless there is an opportunity for the learner to discuss this sort of apparent conflict in teaching, he will see the teaching content chosen by the two as demanding a choice of him and be forced to discard one."

There follows a series of quotations which Dr Eastwood variously labels as tendentious and dogmatic. The reader must judge just how dogmatic are such quotations as "The behavioural sciences teach him to observe movement as a signal of despair, anxiety, flirtatiousness and so on," or "The teenage girl with dysmenorrhoea may mirror her mother's experience." If they wish a yardstick by which to measure the doctrinaire quality of such

statements, we would refer them to Dr Eastwood's own "In my opinion, psychosomatic ideas have presented a considerable impediment to the serious study of a number of important diseases." Is the truth not simply that Dr Eastwood values only one part of clinical medicine, that concerned with physical measurement?

It has been our intention in this detailed reply to Dr Eastwood's criticism to be explanatory rather than defensive. We are quite happy, however, to move on to the offensive.

It seems to us that what Dr Eastwood's letter has made manifest is not our own 'scientific slackness' but his own uncritical prejudices about clinical medicine. We recognise them, we understand them, but we cannot share them. It was our intention in writing this book, and it remains our intention, that they will not be shared by the future general practitioner.

## REFERENCES

- Eastwood, N. B. (1974). *Journal of the Royal College of General Practitioners*, 24, 796-7.  
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JOHN HORDER, *Chairman*  
PATRICK BYRNE  
PAUL FREELING  
CONRAD HARRIS  
DONALD IRVINE  
MARSHALL MARINKER

14 Princes Gate,  
Hyde Park,  
London, SW7 1PU.

## VASECTOMY FOLLOW-UP

Sir,

From his follow-up study of 175 vasectomised men, Dr Drury reports an improvement in the physical and emotional relationships of over 50 per cent. I doubt whether he is justified in drawing these conclusions from his data.

There is little argument that vasectomy is an efficient means of producing irreversible sterility with no physical harm to the patient. Most reservations concerning the operation lie in the psychological sphere and it is here that research needs to be done. It is now widely agreed amongst psychiatrists (whether for or against vasectomy) that the removal of a man's fertility by a mutilating operation causes a profound and serious disturbance to a man's body-image, evoking fears of castration, impotence, and demasculinisation. Psychological readjustment to his damaged self-image is made by seeking reassurance that the feared loss of sexuality and manliness have not occurred.

The vasectomised man is very likely to be driven by anxiety to dwell on sexual matters and this may be erroneously interpreted as 'increased libido' by the unwary observer. He is also likely to try to reassure himself that his sexual abilities

have not been destroyed, leading to an increase in coital frequency. Ziegler *et al.* (1969) found that men reporting sexual problems after vasectomy (e.g. impotence and premature ejaculation) were also those men reporting the highest increase in coital frequency. From this he concluded that increased coital frequency is a *neurotic*, rather than a healthy, response to vasectomy.

Assuming the psychiatrists are correct, it would seem to be much too shallow an approach to ask men "to rate the effect that vasectomy had upon their feelings of masculinity" or to ask a couple to complete a postal questionnaire (probably together) asking whether their physical and emotional relationships were "better" "worse" or the "same". How, for instance, should the impotent man with increased coital frequency reply? David and Helen Wolfers (1974) in their book *Vasectomy and vasectomania* strongly criticise the Simon Population Trusts 1969 survey of 1,000 cases for using just this technique and say "To ask people to state whether their sexual lives or marital harmony are better, worse or the same, is about as useful as the measurement of electric current with a divining rod."

Fortunately most vasectomised men easily make the required psychological readjustment; a few, disastrously, do not and it is of the utmost importance that this latter group is identified before operation.

More research is certainly needed to help us understand the consequences of vasectomy. In my view meaningful results will only be obtained by independent observers (not the operators) using in-depth psychiatric interview techniques.

HENRY MEADOWS

Hastings House,  
Wellesbourne,  
Warwick.

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Wolfers, D. & Wolfers H. (1974). *Vasectomy and vasectomania*. London: Mayflower Books Ltd.  
Ziegler, F. S., Rodgers, D. A. & Prentice, R. J. (1969). *Archives of General Psychiatry*, 21, 50.

## ASSESSMENT OF APPOINTMENT SYSTEMS

Sir,

Both the Joint Working Party on the General Medical Services (1974) and the House of Commons Expenditure Committee (1974) have recommended that general practitioners should periodically review their appointment systems so as to detect and correct problems. For this reason alone, it was pleasing to read Dr Lloyd's report of a consumer survey of his appointment system, published in your September issue.

Unfortunately this paper demonstrates a number of methodological shortcomings. It is important