Editorial

DAEDALUS, ICARUS AND GENERAL-PRACTICE RESEARCH

THE Scottish Home and Health Department publishes several times a year the *Health Bulletin*, which describes developments in the Health Service and publishes articles contributing to the care of patients and promoting understanding of the Health Service.

The September 1974 issue is remarkable in many ways. Apart from setting forth the views of the Chief Scientist on the research organisation in the integrated health service, which makes interesting reading, what is striking is that out of seven research contributions, three are by doctors with the M.R.C.G.P. among their qualifications.

One article in particular requires mention. Dr A. D. Shaw, a vocational trainee in general practice has, with a physiotherapist of the hospital where he was working, published a paper on the rehabilitation of patients with myocardial infarction, through what he calls an intervention clinic. This unassuming paper in its neat and factual way clearly demonstrates (though the authors only cautiously claim this) what an interested doctor can achieve. By taking the trouble to map out for his patients a careful progressive physical rehabilitation programme, a doctor can get his patients more effectively fit, as measured by physical performance, and help them to return to work sooner than post-myocardial infarction patients who do not achieve the same attention and interest. A blinding new truth? Not at all, but it emphasises that we have the power, though we may not use it adequately for various excusable and inexcusable reasons, to help our patients not just with pills, potions or certificates—but with management and encouragement.

Such intervention clinics in hospital carry a message for general practice to do better than we have done in the past, and attempt to rehabilitate our patients by greater guidance and support of the individual. Special equipment is not necessary; as Shaw points out, graduated exercise can be performed with the minimum of gadgetry.

The same issue of the *Health Bulletin* included an insertion explaining the research organisation in the integrated health services. The rest of the publication inspires confidence in the future of general-practice research but this statement of policy, with its diagram of planning and research advisory committees is frightening. General-practice research, which appears to be budding so energetically albeit timidly in so many places, may be suffocated.

While the Scottish Home and Health Department or the Department of Health and Social Security Chief Scientists' plans appear to be reassuring that general practice will be encouraged, all the evidence, alas, points to the continuing dismal and minimal support for research in general practice.

The figures for 1973/74 for decentralised general-practitioner research, i.e. research not based on general-practice research units or academic research departments, show that out of a total £1,292,000 decentralised research allocation to England only £13,500 is allocated to general practice.

It is difficult to obtain the total annual figure for grants (including the Medical

Research Council and all the major research supporting Foundations) for research in general practice. If we estimate a total of £1,000,000 spent on general-practice research as an almost certain over-estimate, we still spend considerably less than one per cent a year of the cost of community care (the patient outside the hospital). Considering that at least 80 per cent of all ill health is comprehensively supervised by general practitioners, this figure hardly inspires confidence for the future.

While the Chief Scientists' organisations have sought and obtained the help and membership of some excellent general practitioners to serve on their advisory bodies, we fear that they may be facing the walls of Jericho, but having their trumpets muted. By the sheer weight of the academics on these committees and by the procedural hurdles of the committee structure, general-practice projects are all too readily downgraded, especially when they do not fit into the theoretical schemes of committee guidelines devised by those who do not have to deliver day-to-day care.

Research carried out in institutions by institutions has been the life blood of progress in the past, but to assume that simply extrapolating from that to the community without study and assessment is likely to stultify further advances in the future. Like the wings made by Daedalus for Icarus which melted in the heat of the sun, the best of such theoretical studies may shrivel up in the heat of everyday life in the community.

We hope that the Chief Scientists' Organisation will encourage work that can only be done in general practice, and not stifle, through lack of funds, the stimulation essential to progress and good patient care.

REFERENCES

Kay, Sir Andrew. (1974). *Health Bulletin*, **32**, 204–10.
Shaw, A. D. (1974). *Health Bulletin*, **32**, 185–8.

REASONS PHYSICIANS LEAVE PRIMARY PRACTICE

Findings indicate the decision to change careers was a product of multiple factors, including overwork, unsystematic approaches to patient care, and unavailability of techniques for enhancing the capabilities of private practice. The increasing availability of alternative career pathways offering high prestige, controlled hours and workloads, and other advantages was also a factor in these decisions.

It was suggested that this attribution might be substantially mitigated by inclusion of organisational, administrative, and interpersonal aspects of practice in medical training and continuing education.

REFERENCE

Crawford, R. & McCormack, R. C. (1971). *Journal of Medical Education*, **46**, 263–268.