

The interface

'INTERFACE' is an inelegant word, but it is fashionable. It is used, perhaps a little pretentiously, by the medically orientated press to describe the contact between doctors and their patients. It has been used for longer by the biogeochemists to describe the area of contact between living creatures, man included, and the environment in which they live. Physicists, however, have used the word for longer still and are accustomed to describe changes which may or may not occur where two substances or elements meet.

General practitioners do indeed operate at the level at which people bring evidence of some mental or physical maladjustment, perhaps a symptom, or at least something that is at once recognizable as a clinical entity. Whether it is an indefinable headache or established measles, the clinical presentation is the result of the patient's presence at what is to him a very important interface.

Were life possible in isolation, deprived of light or dark, it might be that individuals could be insulated against their surroundings. Life requires nutrition and respiration, only two of the means by which the environment is actually consumed by man. Changes in his surroundings enter man's awareness through his sensory receptors—eyes, ears, skin surface, and labyrinth, during every waking moment. He is exposed to the group environment from crowded pavements to television. The flow of impulses is never ending and of almost infinite variety. His response to the total input of external stimuli indicates that he is alive; the manner of his response displays his individuality.

General practice is about individuals and the ways in which they react to what goes on at this interface. They are the first professionals who can watch and record the things they see. No one is as well placed as the family doctor to sort out interrelated environmental, social, and nutritional factors. Doctors see the consequences of these interactions first and indeed since many live and work among their patients they may be exposed to

similar influences themselves, while clinical scientists in hospitals see natural history only at a distance. Research workers in social medicine, or what used to be 'public health', often work on selected samples or routinely collected data from such large populations as to deprive it of any local significance.

General practitioners cannot be reminded too often that they are the field naturalists of medical science today, and that their special opportunities require of them their own approach to their particular kind of epidemiology. This, they will find, is a matter to be shared less with others in medicine but more with the non-medical scientists who have made environment science, physics, chemistry, sociology, geography, and many other disciplines their particular research interest.

Paradoxically, it is easier for generalists in practice to make contact with specialists in non-medical science than for those whose medical interests are circumscribed. Every day the mind of the doctor in practice is continually refocussing. Problems of industrial health may follow acute infection or psychological disturbance. A doctor may have to think and talk his way into a dozen disciplines of medico-social relevance in one morning's session. He is at home among the experts in medicine, and the experts in science with whom he will work increasingly on the problems of this particular interface are equally approachable. Whether the expert is an American biogeochemist or an academic in a British university at work on behavioural psychology matters little. There is enough common ground.

If medical science is to advance as it should it will be by harnessing the advances in technology to the elucidation of new problems derived from new approaches to source material. The source material is in our practices and it is for us to recognize this and help our colleagues in science with information and access that they can obtain in no other way. We in general practice hold the key to much new knowledge at this interface and we must not keep it to ourselves.

Dr R. J. F. H. Pinsent

IN NOVEMBER 1977 Dr R. J. F. H. Pinsent retired as a member of the Council of the College. In this way the Council lost its last direct link with the original

Foundation Council, as he had served throughout those 25 tumultuous years.

With the benefit of hindsight it is now clear that a

College of General Practitioners would have been formed at some time, but the question of when and how is far from clear. McConaghey (1972) showed that early attempts in the nineteenth century failed and the final success in the 1950s hinged on a tiny group of people who pursued the quest with quite extraordinary energy. Membership of the Steering Committee included equal numbers of consultants and general practitioners, of whom Robin Pinsent was one. Early on he revealed some of his characteristics: wide vision, great energy, capacity for hard work, and a skill in expressing himself on paper.

There can be no doubt that the timing of the foundation was of critical importance, because general practice in Great Britain was disintegrating rapidly, and at that time there were no sister Colleges in Europe, Canada, or Australia to give support. It would have been easy for the new College to lose its way and there can be no doubt that it was through the vision of men like John Hunt and Robin Pinsent that the right framework was found in which general practice could begin to live and breathe.

Pinsent's subsequent involvement with the College has been remarkable: He initiated the development of general practice research. From this came the early *Research Newsletters*, of which he was the first Editor, which led directly to the present *Journal*. He saw generations ahead of his time that good research in general practice would require not just critical thought but would be dependent on developing new methods of data recording in general practice.

He was the first to recognize that the general practitioner's list of registered patients could become the denominator for new morbidity rates. In a unique collaboration he and Donald Crombie developed the College Records Unit in Birmingham, where various means were devised for doctors to record the morbidity with which they were dealing in everyday practice. Their

weekly returns were quickly extracted and the collective data regularly published for the benefit of epidemiologists and administrators at home and overseas.

Ian Watson introduced the idea of a multiobserver study in general practice to the Research Committee in its first meeting in February 1953, and this example was followed in the two national morbidity studies, both inspired and led by the Birmingham Research Unit of the College.

As Research Adviser Robin Pinsent has stimulated and encouraged countless young general practitioners. He has contrived to make himself available to give not just technical knowledge but to pass on some of his own enthusiasm for research in his discipline. He participated also in national and college committees, notably the Gillie Committee of 1953, and in virtually all the College's committees at one time or another; in particular, he took leading roles in the Research, Awards, and Ethical Committees. Unlike those who hit on a good idea and then spend much of their lives developing it, Robin Pinsent has been able to look widely outside the immediate day-to-day pressures and visualize the possibility of new developments in general practice not yet charted, particularly in the international field. His constant cry for more awareness among practitioners of the possibility of ill health being caused by environmental factors is a typical example. He delivered the 1962 James Mackenzie Lecture and wrote articles in both medical and historical journals.

Among the men who helped to move the mountain of general practice the name of Robin Pinsent will forever be remembered as one of the greatest of our founding fathers. We wish him a happy and productive retirement in his native Devon.

Reference

McConaghey, R. M. S. (1972). *Journal of the Royal College of General Practitioners*, 22, 775-788.

An opportunity to learn

INSULARITY is by tradition one of the sins of the British and is supposedly associated with Britain's island state thus symbolizing isolation from the main continent of Europe.

Certainly it is true that the preoccupation of British general practitioners during the middle of the twentieth century with their NHS, their College, and with their successive revolutions in organization and education has made them less conscious than might have been expected with similar developments in other countries in the world.

However, general practitioners have now been working in the NHS for nearly 30 years, they have reached the silver jubilee of their College and have survived many internal revolutions in terms of practice premises, organization, and education. It is therefore an appropriate time for British general practitioners to take stock of events in general practice in other countries of the world.

The first problem is to obtain the basic factual knowledge about what is happening, and here there is a tremendous deficiency. Relatively few British general