to the SIMG Secretary, Klagenfurt, Austria, labelled SIMG-Janssen Prize.

MIGRAINE

The Third International Symposium on Migraine is being held at the Hotel Russell, Russell Square, London WC1, on 17 and 18 September 1980. Further information can be obtained from the Director, The Migraine Trust, 45 Great Ormond Street, London WC1N 3HD.

INTERNATIONAL CONGRESS ON IMMEDIATE CARE

The British Association for Immediate Care in association with other organizations is holding an international conference on immediate care in Brighton from 22 to 25 October 1980. The programme will have Section 63 approval within the United Kingdom and further information and enquiries can be obtained from Miss Sarah Peacock, BASICS, 14 Princes Gate, Hyde Park, London SW7 1PU.

REPORT OF THE HEALTH SERVICE COMMISSIONER

The Report of the Health Service Commissioner for the period August 1979 to March 1980 has recently been published.

Among the cases considered was a complaint by a widow about her family practitioner which suggested among other things that he had failed to offer her his condolences at the time of her husband's death.

The Health Service Commissioner established that the administrator had dealt with this complaint in order to protect the Chairman of the Medical Services Committee "from having too many complaints to deal with", which the Health Service Commissioner regarded as contrary to paragraph 31 of the "Notes on Service Committee Procedure" prepared by the Department of Health and Social Security, which read: "A complaint may not be dealt with on its merits by the administrator without reference to the Chairman whose function it is to decide whether the complaint discloses any reasonable grounds of complaint."

The Health Service Commissioner concluded that it was "imprudent and improper for the administrator to express an opinion on the standard of medical treatment on the basis of a telephone conversation he had with the family practitioner."

The family practitioner committee administrator concerned died before the Health Service Commissioner reported and the Chairman of the family practitioner concerned had accepted that the administrator made an error of judgement in replying in the terms he did and has conveyed his Committee's regrets for this. As a result of this case, procedures have been amended so that all complaints dealt with otherwise under the regulations are reported to the Service Committee Chairmen.

Reference

Clothier, C. (1980). *Report of the Health Service Commissioner.* Selected investigations completed August 1979 to March 1980. London: HMSO.

LETTERS TO THE EDITOR

SPECIALIZATION WITHIN GENERAL PRACTICE

Sir,

Let me take Dr Tudor Hart (April *Journal,* p. 216) gently to task and ask him for the evidence that the "specialoid role" developed in Livingston is not generally popular—with whom, for example? May I also plead for the abandonment of the word 'specialoid'. I am a full-time general practitioner providing a complete range of general medical services for my patients. I happen to have a hospital practitioner appointment in child health—a special interest particularly appropriate to general practice. Many general practitioners outside Livingston—none in it—are police surgeons, factory doctors, and medical referees for insurance companies; others have sessional commitments to various specialties within hospitals. All in common with Livingston doctors have special interests and skills which can be accommodated within their general practices. To use a hybrid neologism to describe such activities serves no useful purpose.

More seriously, let us keep an open mind about the need for looking at different ways of developing general practice to meet the needs of a changing inner city, urban and rural society, in the last 20 years of this century. The Livingston approach never set out to be a final solution but was expected to proceed on an evolutionary basis. The pursuit of special interests in the context of general practice is constantly being reviewed but whatever else is said, such interests, for example in obstetrics, child health, psychiatry and geriatrics, far from limiting generalist skill, enhance it, increase the range of services available to patients and provide at the same time a valuable teaching capability.

Philosophically, I would suggest that a narrow approach to the generalist/specialist debate threatens not only the credibility of general practice but may result in its being constrained by powerful specialist lobbies. Division of the profession must be avoided and sharp boundaries blurred. John Donne's words are appropriate:

"Who makes the past a patterne for next year,
Turns no new leafe, but still the same thing reads,
Seene things, he sees againe, heard things doth heare,
And makes his life, but like a paire of beads."

(Verse letters to Sir Henry Goodyere)

W. J. BASSETT
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Sir,

I would like to comment on Dr D. J. Pereira Gray's reference to my article in his stimulating and commendable lecture (April *Journal,* p. 231). He was wrong to imply that I had assumed care of these anticoagulated patients when in fact it demonstrated one aspect of organization required within a group practice comprising six partners, who take annual leave and weekly half days, man two branch surgeries and make use of a general hospital which does not run an anticoagulant clinic.

The resulting difficulty in quickly contacting the general practitioner about his patient's prothrombin result rendered it more practical (and indeed most successful) to nominate one of us to assess these results in batches. Some

degree of specialization was inevitable but *not* to the detriment of my partners' experience. They have to assume control in my absence, and also be aware of the possible drug interactions when prescribing for their patients. In fact, we all agree there has been negligible intrusion upon my partners' and his patients' relationship.

Therefore, I would like to stress that I do not share Dr Pereira Gray's blanket view against specializing within general practice, as long as it does not breach the continuing care pattern that is so necessary in general practice (as threatened by the Court Committee, 1976). In fact it could well be this lack of mini-specialization that has led to the poverty of clinical research in general practice.

Research to date has been dominated by defining the role of the general practitioner and describing and auditing his mode of practice (often detrimentally). I have wholeheartedly condoned this in the past, but feel that general practitioner research should now change direction: one vast, untapped field is to question, and possibly alter, much of the statistics, theory, and management originating from the hospital specialist of conditions which occur far more commonly in general practice. This is most likely to be achieved by general practitioner 'specialists' who will keep abreast of their subject as well as general topics, and may draw on more patients than their personal list allows. In time we may even take more notice of the theoretical or therapeutic results prepared by one of our own even though he may be . . . just a GP.

R. J. GALLOW

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Hemel Hempstead
Herts.

Reference

Committee on Child Health Services (1976). *Fit for the Future.* Court Report. London: HMSO.

THE MECHANICAL ARTHROPATHIES

Sir,

In November 1948 I was called to a male patient aged 35, who had a severe pain over the right sacro-iliac joint and was unable to stand. It had come on suddenly while he was gardening and he lay on the settee clutching a garden rake. The history suggested that this was a condition of mechanical origin and I therefore proposed to him that I should attempt to relieve it by mechanical means. A manipulation devised ad hoc was entirely successful. The patient was rendered pain free and functionally normal and the condition did not recur. It soon became apparent that mechanical arthropathy of the sacro-iliac joint was one of a group of such arthropathies, mainly affecting the plane joints, such as the intervertebral and costovertebral joints, and subsequently a group of manipulations (Eastwood, 1964) became part of my clinical stock in trade. Last week I was called to a woman aged 37, who had severe pain in both sacro-iliac joints and who was able to stand only in a bent-double position. I manipulated both joints, with complete relief of her pain and disability.

In the 32 years intervening between these two cases, I have successfully manipulated about three or four patients per week in the normal course of my practice work, and have therefore conducted in all about 5,000 immediately successful manipulations of various kinds without untoward incident. How it comes about that a category of disability can be almost totally ignored in the teaching hospitals, and that medical students can qualify as doctors and go into practice without ever having had the opportunity of undertaking manipulations or seeing them done, is a matter for speculation. The General Medical Council, as representative of the public interest in medical education, surely has a responsibility here. Suffice it to say that there is a group of medical conditions usually passed off as fibrositis, neuritis, non-articular rheumatism, or even as psychological illness, which can easily be treated by anyone who takes the trouble to learn the manipulations required. The scientific interpretation of the manipulable lesion is less easy.

N. B. EASTWOOD

71 Victoria Road
Oulton Broad
Lowestoft.

Reference

Eastwood, N. B. (1964). Six manipulations suitable for use in general practice. *Journal of the College of General Practitioners,* 7, 144-146.

THE DIVISION OF BRITISH MEDICINE

Sir,

In his review of my book, *The Division in British Medicine* (April *Journal,* p. 245) Dr D. J. Pereira Gray does not seem to recognize that my history deals mainly with the period before 1948. The development of general practice since the Health Service began is discussed only briefly and therefore it was not appropriate to explain at length the contribution made by the Royal College of General Practitioners. A fuller analysis of the College's influence will appear in my next book which will cover the period from 1948 onwards in greater detail.

It is also important to recognize that my book does not neglect those who formulated the philosophy of general practice which the Royal College inherited. The leading proponent of this school was Sir Henry Brackenbury of the British Medical Association and a good deal of my study is concerned with his policies and influence, presented in a full and fair manner. In the biographical profile devoted to him, I have made it clear that he was one of the great medical leaders of this century.

In describing his philosophy as the "social work concept of general practice", I do not mean to imply that it excludes the treatment of organic disease. What it suggests, rather, is a tendency to assign a higher priority to the social and psychological components of illness. Brackenbury believed it more important to extend general practitioner interest in this direction than to create conditions of work that would enable him to enlarge his treatment of organic disease. The Royal College apparently endorses this view, for the doctor it has made its Dean of Studies, Dr J. S. Norell, declared in 1965 that the general practitioner "would rather be recognized as the most versatile of medical social workers than the least of medical men" (see p. 311 of my book).

If my book devotes a good deal of space to the policies of socialist groups, that is only understandable, for it was the Labour Party that created the National Health Service and one cannot understand Labour policy on health care without tracing the influences that shaped it.

As for Mackenzie, it is true that he held an appointment at the London Hospital (and at other hospitals as well) but this did not provide him with a proper, satisfying or enduring place in the hospital world. That is what I meant by the words quoted by Dr Pereira Gray and they should be read in conjunction with the sentences that follow, but I should have stated the whole point more clearly so as to avoid any misunderstanding. Lord Knutsford, the chairman of the London Hospital, apparently had great difficulty securing beds for Mackenzie after he joined the staff about 1913 and, according to the obituary notice which appeared in the *British Medical Journal* (31 January 1925, p. 242), Mackenzie's wards were taken from him and used for military purposes after the First World War broke out in 1914. He thus seems to have had