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.

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Reference

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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.

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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