medicine, but throughout the scientific world. During his 17 years as Editor, McConaghey was criticized for insisting on references, many of which he added himself. The corresponding struggle in the 1970s has been to show that the principles of scientific thought are as relevant to general practice as to other clinical disciplines.

Truth is sometimes dull, accuracy is tedious, but science must be convincing.

Norell (1980), Dean of Studies of the College, has written: "It does seem rather pointless to wade through pages and pages of dull, but no doubt impeccable material, merely to discover that the null hypothesis is confirmed." Not so. Consider the distinguished doctors of the past who used blood letting for many ills. They changed only when the null hypothesis (that the treatment was not effective) was finally tested and could not be refuted. The null hypothesis still has an important place in scientific thinking. In the classic study by Mather and colleagues (1976), the null hypothesis was that men under 70 sent into hospital with coronary thrombosis would fare no better than those treated by their general practitioners at home. Were this null hypothesis not reasonable it would have been unethical. It remains to be refuted.

Those researching the growing edges of any discipline are bound to introduce challenge and change. Research is all about asking questions and its results often carry the implication that some new approach may be better than existing practice. Scientific journals demand effort and concentration from their readers, who are constantly confronted with information that does not fit previous thinking. Such journals ask of their readers tolerance and a readiness to accept change. In short, they can be tough and tiring to read, though whether they are necessarily "dead boring" (Norell, 1980) must remain a matter of opinion between the author, editor, and reader.

Dual role

Another tension lies in the dual role of the *Journal* as the *British Journal of General Practice,* which it has now become both in fact and name, and the essential need to disseminate information about the College. The proposed College newsletter, which has been under discussion since 1978, could help considerably.

Time of change

At the time of only the second change of Editor in 26 years it is right that the policies of the *Journal* should be questioned and debated. We hope that in the years ahead this *Journal* will continue to provide a medium through which those concerned with general practice can communicate with each other, and to act as a forum for evidence and ideas for the broadest of all the branches of medicine.

Acknowledgements

No monthly journal with a circulation of about 10,000 could be produced without the help of a large number of people, especially in the College, the publishers, and the printers, and voluntary helpers throughout the English-speaking world. The Editorial Board has borne the brunt but five times their number of other colleagues have worked quietly, without public notice, in their spare time to give advice.

We would like to thank all those who have played a part in the development of this *Journal* during the last decade.

References

Journal of the Royal College of General Practitioners (1975). Mac. Editorial. **25**, 627-628.

Journal of the Royal College of General Practitioners (1975). The maternity grant—room for reform? Editorial, **25**, 81.

Journal of the Royal College of General Practitioners (1976). The arts as aids to learning. Editorial, **26**, 555-556.

Journal of the Royal College of General Practitioners (1978). Clinical work in general practice. Editorial, **28**, 707-709.

Journal of the Royal College of General Practitioners (1979). Medical audit in general practice. Editorial, **29**, 699-700.

Lancet (1980). Medical audit in general practice. Editorial, **1**, 23-24.

Mather, G. *et al.* (1976). Myocardial infarction: a comparison between home and hospital care for patients. *British Medical Journal,* **1**, 925-929.

McConaghey, R. M. S. (1960). The birth of a medical journal. *Postgraduate Medical Education,* Suppl. **36**, 306-308.

McWhinney, I. R. (1972). Academic departments of general practice. *Journal of the Royal College of General Practitioners,* **22**, 286-287. (Quoted from *Canadian Family Physician,* **18**, 2.)

Norell, J. S. (1980). The *Journal.* Letter. *Journal of the Royal College of General Practitioners,* **30**, 567.

Scott, R. A. Murray (1970). The development of the College *Journal. Journal of the Royal College of General Practitioners,* **20**, 255-262.

Family doctors for doctors' families

ONE of the main principles of general practice in the National Health Service in the United Kingdom is that every person, regardless of age, sex, income, or social class, is entitled to a personal doctor.

Over 98 per cent of the British population are registered with general practitioners, but one important group which has partly held back is doctors themselves and their families. The reasons for this are difficult to unravel but have become better understood in recent years.

In the early days of 1948 the place of the primary physician was often seen within somewhat limited perspectives. The role of the general practitioner had not been seriously studied, published, or taught. It is not surprising that many doctors outside general practice simply did not understand the role of the practitioner, and behind Henry Miller's question "What do general practitioners do?" lay another question of "Was it worth doing anyway?". It is not surprising, therefore, that many doctors in the hospital service simply did not

bother to register with or consult general practitioners, confident that when they needed medical advice there would always be a specialist to whom they could turn directly for care.

General practitioners were rather different. They appreciated the necessity for registration and the majority did register, but often only casually, either with their own practice or with its neighbour, and frequently without a careful and professional analysis of the pros and cons of their own most intimate patient/doctor relationship.

Over the years the consequences have gradually become clear, and the pattern is changing quickly as more doctors in all branches of medicine turn more regularly to general practitioners and choose them with much greater care. Trainees have been a useful catalyst as they usually register promptly and rightly expect a comprehensive medical service.

Doctors' reactions

Doctors' families are a vulnerable group (*Journal of the Royal College of General Practitioners,* 1978). They are vulnerable in particular because the health care which they need may be provided less professionally than for many other patients. The first problem is the initial reaction to symptoms. The tendency is for the doctor in the family either to over-react or to under-react to the problem.

Over-reaction can involve initiating a whole series of investigations which tend to be associated with multiple and often direct access referrals, carried out at speed and short-circuiting the usual procedures. The consequences are often continuing difficulties in communication, and a diminution of the contribution which can be made by all the other doctors concerned, including both the general practitioner and the various specialists. The former finds himself called to a family where tests have already been started and quite often treatment, typically antibiotics, has already been begun. He is rarely consulted at the usual time in the natural history of the condition and so is denied the chance of getting to know the doctor's family as he does other patients, and may be deprived from building up the usual doctor/patient relationship with the family as a whole.

In particular, he may be prevented from taking one of the most important decisions of all for a primary physician, namely, whether intervention at all is right or wrong.

The opposite response of under-reaction is much more common and potentially more serious. The doctor-patient is often reluctant to seek care, will usually delay in seeking advice, and sometimes deny the illness. Furthermore, once in the consulting room a doctor may be hesitant to reveal personal information, especially feelings of depression or relationship problems at work or at home (Nelson, 1978), unless he or she feels absolutely secure within a professional doctor/patient relationship and has specific assurances about the confidentiality of the information and the custody of the records.

Similarly doctors' families, especially spouses, are inhibited from seeking advice. At a recent Tamar Faculty symposium on this subject to which doctors' spouses were invited, not one but several doctors' wives were heard to say in the discussion groups that they wished, oh how they wished, that they too could have a family doctor! Their problem, it seemed, was that they were imprisoned in doctor/patient relationships which were not professional enough. They were either registered with their spouse or one of his partners, or a neighbouring practice. Apparently doctors' spouses often suffer in silence and are not getting the support to which many of their spouses' patients would automatically be entitled.

Doctors choosing doctors

The role of a doctor's doctor is not easy, but a few principles are emerging. Such a doctor should command respect both as a person and a clinician, competent simultaneously in both the physical and behavioural aspects of medicine. He or she should ideally be a person in whom both the doctor and his spouse can confide and with whom real communication is possible. In practice, it often seems to work best if the doctor's doctor is not very much younger than the patient.

Where there is a choice, it is usually better for general practitioners to register outside their own practice. Partners are not the first choice as personal physicians but, in some rural areas and some special situations, a partner can still be the doctor's doctor; in the end it is the quality of the professional relationship that counts.

Another guiding principle is a clear agreement about the range and appropriateness of self-care. Simple self-care is naturally reasonable and to be encouraged, but for depression it can be downright dangerous.

As general practice moves into systematic preventive or anticipatory care, general practitioners are increasingly looking for opportunities for health promotion in more and more consultations (Stott and Davis, 1979). It is doctors and their families who may be missing out. It is the middle-aged male doctor who may not be getting his blood pressure checked on routine case finding like other men, and his wife and daughters who are not always getting their rubella immunizations and cervical smears. Typically, it is the doctor's child about whom nobody is quite sure when the last tetanus shot was given.

Doctor-patient/doctor relationships

The doctor-patient naturally sets a special problem for his general practitioner, but also creates special opportunities. The doctor-patient knows, as only doctors know, just how significant certain symptoms are. Repressed emotion and anxiety about their significance is natural. The doctor in the doctor role is thus deprived of

much of the traditional authority of the doctor by virtue of the patient's equal knowledge. This can be disturbing at first but creates an opportunity to establish the equal and partnership relationships with patients to which general practitioners are now aspiring. It is easier to have a full and frank discussion if the patient already knows the basic facts, and there is much less danger of the doctor being seduced into making authoritarian statements if the patient is the local specialist on the subject.

Conversely, general practitioners must somehow ensure that they retain a reasonable authority in the consultation in order to assess the problems objectively and arrange an appropriate professional response. Striking a balance is taxing and challenging but may offer a model of doctor/patient relationships in the twenty-first century when patients, through the information explosion, will become much better informed than now.

Difficulties ahead

Despite the current trend for doctors and their families to see general practitioners much more regularly, some difficulties are arising.

First, some of the specialist organizations, for example the Association of Anaesthetists (1979), are adopting a policy where, perhaps unwittingly, they seem to be recommending direct referral of some of their colleagues to other specialists. The suggestion that anaesthetists in trouble should be referred quickly and quietly to psychiatrists is contrary to a main principle of general practitioner care, and is not necessarily in the interests of those anaesthetists. Specialist doctors, when patients, may benefit in particular from generalist doctors as doctors.

Similarly, the General Medical Council, as it begins to grapple with its new responsibilities for the sick doctor, is setting up panels of specialists. It too may be in danger of introducing into its new procedure a relationship between doctors as patients and specialists which may be contrary to that normally pertaining to other patients.

It may be timely for those organizations representing general practitioners to examine this problem and to ensure that all doctors, when patients, are referred first to their own personal doctor rather than direct to a panel of specialists.

Traditional privilege

It is one of the oldest traditions in medicine that doctors regard it a privilege and an honour to be asked to look after colleagues and their families. That tradition is right and remains appropriate; it has been preserved most notably over the years by many of the senior consultants and it is a tradition of which the medical profession can be proud.

Two years ago this *Journal* agreed that "the time has indeed come to consider the (family) doctor's family". Let general practitioners now acknowledge their responsibilities and make it clear that they too regard it as an honour and a privilege to be a family doctor to a doctor's family.

References

Association of Anaesthetists of Great Britain and Ireland (1979). Help for the sick doctor. Press release. Available from 475/478 Tavistock House South, Tavistock Square, London WC1H 9LG.

Journal of the Royal College of General Practitioners (1978). The family doctor's family. Editorial, **28**, 579.

Nelson, S. B. (1978). Some dynamics of medical marriages. *Journal of the Royal College of General Practitioners*, **28**, 585-586.

Stott, N. C. H. & Davis, R. H. (1979). The exceptional potential in each primary care consultation. *Journal of the Royal College of General Practitioners*, **29**, 201-205.

Dr S. L. Barley

ON 1 January 1981, Dr S. L. Barley takes over as Editor of this *Journal*.

Dr Barley, who is married with three children, is a principal in a three-partner training practice in Sheffield. He is an active member of the Trent Faculty, and has been its representative on the College Council.

After a year reading classics at Cambridge, he qualified from St Thomas' Hospital Medical School, where he was awarded the John Simon prize for epidemiology. He worked as a general medical officer in Tanzania for two years before completing vocational training for general practice at Ipswich. In 1972 he was the first winner of the Fraser Rose Gold Medal for the candidate with the highest number of marks in the College's membership examination. He has had articles published in the *Lancet* and in this *Journal*, and he holds a part-time appointment in the Department of General Practice and Community Care at the University of Sheffield.

Dr Barley has been closely involved with the *Journal* for several years, becoming a member of the Editorial Board in 1973 and doing an increasing amount of work for the *Journal* and the *Occasional Papers*.

The College appointed him Deputy Editor on 1 January 1980 and he now becomes only the third Editor of the *Journal* in 26 years.

We congratulate him on his appointment and wish him and the *Journal* every success in the future.