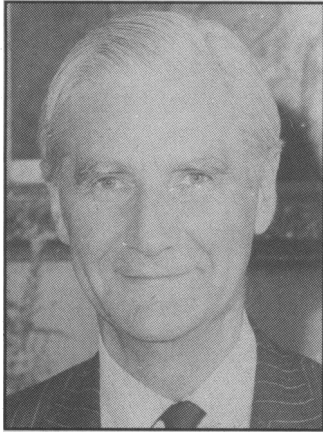


## Oasis or beachhead

ALASTAIR G. DONALD, OBE, FRCPE, FRCGP



*Alastair G. Donald*

**P**RESIDENT, it is a very great honour to be invited to give the James Mackenzie Lecture. I feel humble when I consider the stature of my predecessors as Mackenzie Lecturers, but proud to be associated with them in honouring a man who has symbolized our aspirations for general practice. I am also grateful for the opportunity to present a personal perspective on practice and on the role of the College.

I first became aware of Sir James Mackenzie when I was a schoolboy. I quickly learned that he was held in reverence by my general practitioner father, who, when I was studying biology at school, introduced me to Mackenzie's dictum 'A heart is what a heart can do.' My father graduated in medicine in Edinburgh in June 1907 and almost immediately left for Burnley where, for a short time, he worked with Mackenzie before Mackenzie left Burnley for London. It was obviously this association, however, that led my father to hold him in such respect and Mackenzie's books were prominent in his library. Mackenzie and my grandfather were contemporaries and both sons of farmers living within 30 miles of each other in the East of Scotland, my grandfather graduating in medicine from Glasgow in 1877 while Mackenzie graduated in Edinburgh in 1878. I assume that they knew each other for this would explain the coincidence of my father leaving Edinburgh, where his own father was in practice, to travel to Burnley unless it was simply to fulfil Dr Johnson's assertion that 'The noblest prospect which a Scotchman ever sees is the high road that leads him to England.'

I learned little more about Mackenzie during my undergraduate career but soon after I entered general practice in Edinburgh I was invited by Richard Scott to join his part-time staff in the Department of General Practice, the surgery premises of which were about to be accommodated in the new Mackenzie House. Dick Scott was, of course, the first professor of general practice in the world on his appointment to the Mackenzie Chair in 1963.

When I was elected to the fellowship of the Royal College of Physicians of Edinburgh, like all fellows I signed the Fellowship Roll with James Mackenzie's pen which was presented to the College by Sir John Parkinson. Later in 1983 I was fortunate enough to be awarded the Mackenzie Medal from that College, the first award of which was made to William Pickles. Finally,

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my family has strong links with St Andrews in Fife which is not only the home of the royal and ancient game of golf, but also the town in which Mackenzie established his research institute following his retirement from London. My cousins, who live in St Andrews, can recall as children attending the institute and they remember well Mackenzie's strong Scottish accent undiluted by his residence in London as the leading cardiologist of his day.

In these ways James Mackenzie has touched on my life and it is therefore a very particular privilege for me to give this lecture which bears his name.

### Practice origins

Before he committed certain sacred cows to the guillotine in his 1984 Pickles Lecture,<sup>1</sup> the College's intellectual Robespierre, Jack Norell, established his credentials for making a personal statement. My credentials lie in a combination of inheritance, observation and experience of general practice over a period of more than 50 years, and as a founder associate of this College.

The practice that has provided my clinical experience was founded by my grandfather in 1883. He was succeeded by my father and then by me and happily my present partners include my daughter thus providing a continuity of four generations serving, over a period of 100 years, the population of Leith which is part of the City of Edinburgh. We can claim, therefore, to have met at least one of the characteristics of general practice, namely, 'continuity of care' — even if we can say relatively little about the quality of that care. Unfortunately few facts exist to enable me to compare the practice in my grandfather's and father's lifetime with my own and most of the comments I can make rest mainly on my own observations. To these observations is added a great deal of anecdotal evidence provided by the many current patients who were looked after by my father and my grandfather. There is also the physical evidence of practice provided by inherited instruments and equipment such as the forceps for extracting teeth and the surgical knives reminding us of the range of skills employed by a general practitioner in the past. A microscope, a bunsen burner and test tube racks recall the evenings I spent assisting my father to examine urine and discover the eccentric behaviour of that liquid when energetically heated. Obstetric forceps and chloroform masks remind us, as Irvine Loudon has done, of the importance of midwifery in the history of general practice.<sup>2</sup> 'Your father brought me into the world' is more than a statement of fact it is a passport to a continuing relationship and responsibility which I, for one, have been proud to inherit. It is not, however, a passport that I can offer to my daughter.

My grandfather was a stern figure whose strength of personality and authoritarian manner were obviously important instruments of therapy. My father, on the other hand, perhaps possessing a wider therapeutic armamentarium, appears to have inspired both respect and affection. The premises from which they worked hardly changed during their lifetimes and both used the same consulting room and waiting room contained in the fairly large private house situated within the working class community which the practice served. Living in that house and working in that community I have observed the social and professional transition of the general practitioner over half a century.

During the 1930s my father, a single handed practitioner, was able to employ a cook, a housemaid and a nanny, while a chauffeur had replaced my grandfather's coachman but the only help directly related to the practice was provided by my mother who gave a constant telephone answering service and expectantly sent

out accounts which were, I recall, usually for 2/6d a consultation. When patients attended the surgery they rang the front door bell and were shown into the waiting room to await the consultation. Each patient was then ushered into the consulting room by my father, often dressed in a black jacket and pin striped trousers. When, later, I observed his consultations as a student I was conscious that although clinical practice was dominated by bacterial infection, consultations seemed as much concerned with emotional problems as with physical disease and above all they seemed unhurried. Undoubtedly, however, my father worked hard and was delivering some 100 children a year during the 1930s when infant mortality was 66 per 1000, compared with 11 per 1000 in Edinburgh today.<sup>3</sup>

My father tried on a number of occasions — all unsuccessful — to form a local clinical club but his contact with his peers was almost entirely social, on the golf course or round the snooker table. He was available in the evening and by night to respond to emergency calls but had only a moral obligation to do so and if for any reason he was unavailable, the patient required to find help from a neighbouring practice. Although my father's life was hard the pressure did not seem to be intolerable prior to the introduction of the National Health Service (NHS) in 1948. It was only then, when they came to register, that my father discovered how many patients regarded him as their doctor and the figure turned out to be some 4500.

My father only experienced five years of working in the NHS and died in 1955 but life was obviously very different socially and professionally. There was little or no domestic help for my mother after the war and my father, now dressed in a lounge suit, drove his own car and required his son to wash it. Although financially he became more secure the personal satisfactions were obviously less, for with the introduction of the NHS the floodgates of unrestricted patient demand had been opened, releasing an onslaught on British general practice which almost succeeded in destroying it and to which it is, in effect, still adjusting. In 1947 4 500 000 prescriptions were issued in Scotland but in 1951 the number had risen to 21 000 000. The Collings Report<sup>4</sup> in 1950 revealed just how inadequate the structure and process of general practice were in this new situation and with general practice at its lowest ebb it was the creation of the College — an act of great imagination and courage — responding to the challenge of Collings which allowed a new general practice to begin to arise like a phoenix from its own funeral pyre.

### What have we gained?

Some of you may have read *The youngest science: notes of a medicine watcher* by Lewis Thomas<sup>5</sup> in which he contrasts the kind of medicine practised three quarters of a century ago by his father with contemporary 'scientific' medicine with all its power, theory and technique. He asks the questions 'What have we gained?' and more importantly 'What have we lost?' He describes a situation where his father, unable to effect a technical cure, was nevertheless ceaselessly available as a kind of universal confidant and friend to the position today where there is an increasing distance between doctor and patient imposed by technological medicine, and it is this theme that dominates Thomas' reflections on his own career. He comes to the predictably ambivalent conclusion 'If I develop the signs and symptoms of malignant hypertension, or cancer of the colon, or subacute bacterial endocarditis, I want as much comfort and friendship as I can find at hand, but mostly I want to be treated quickly and effectively so as to survive if that is possible.'

Thomas thus identifies the challenge and the dilemma for contemporary general practice, namely the need to reconcile the accelerating advance of medical knowledge and skills — *scientia* — with a warm and caring relationship — *caritas* — in an environment constrained by intense competition for resource allocation in a nation with a relatively declining gross national

product, but rising expectations from medical care. The 'quality initiative'<sup>6</sup> launched and developed by Donald Irvine and the College Council has therefore been important in philosophical and practical terms by indicating a direction to follow in evolving a strategy for the future survival and development of general practice. A beachhead has been established and in the developing offensive where the shape and content of general practice are being redefined I have the opportunity to identify those priorities, some of which have their origin deep in the history of practice or of this College, which I believe must be the components of the new synthesis in general practice relating *scientia* and *caritas*.

### The personal doctor

A quarter of a century ago Sir Theodore Fox, then Editor of *The Lancet*, identified the most fundamental of those priorities. On his return from America he wrote an article deploying his philosophy for the future of British general practice.<sup>7</sup> He challenged the title 'general practitioner' claiming that 'In thickly populated countries like Britain the truly general practitioner is extinct. Many so called general practitioners no longer do obstetrics, advise on babies, set fractures, sew up lacerations, test eyes, or prescribe for diabetics.' Thus the title 'general practitioner' he suggested was obsolete. He preferred the words 'family doctor' because they had a friendly warmth, but the facts are that few general practitioners look after whole families and so Fox went on to suggest that the doctor we all need, while no longer a general practitioner, and not even a family doctor, nevertheless had an essential characteristic which was that he looked after people as people and not as problems. 'A person whom another person in difficulties can rely on as a friend with a knowledge of what is feasible but also with good judgement on what is desirable in the particular circumstances and an understanding of what these circumstances are.' The more complex medicine becomes, he said, the stronger the reasons why everyone should have a personal doctor, 'who will take continuous responsibility for him and, knowing how he lives, will keep things in proportion — protecting him if need be from the zealous specialist.'

Fox recognized that the future of general practice depended on its ability to provide high quality of care and he was concerned as medical technology advanced at the implications that this would have for personal doctoring. To survive, the personal doctor must be good enough to justify his independent status, possessing the knowledge that comes of a continuing interest in medicine, together with a trained and critical judgement. If he is fortunate enough to have a 'therapeutic personality' so much the better — to enable him to carry out what Balint called the 'apostolic function' of the general practitioner — but while we should like our doctor to be always on hand we also want him to be a well-balanced man with a life of his own and not a tired obsessional. Fox therefore saw that the ability to be a personal doctor might be inhibited by the growth of the group and he had severe reservations about the added impersonality that was likely to result from a movement of consultations from the doctor's home into the more institutionalized environment of the health centre. He recognized the tendency of professional groups to take on new functions by deputing old ones to the group below. The nurse and social worker, following their upward course, would relieve the practitioner of much of his old work and this could also erode the concept of the personal doctor. He reluctantly accepted, however, that those who would like to keep the old system could not hope for much support from a public which had got rid of small shops in favour of supermarkets in spite of protestations in favour of the local grocer.

Fox therefore anticipated the conflict discussed by Thomas but reached a conclusion to the dilemma which is fundamental, for he made clear that the survival of the general practi-

tioner would depend not only on inevitable structural changes and delegation, but on our ability to control these changes, preserve the feature that is most central to our vocation which we have inherited through generations and which is embraced within the title 'personal doctor'.

### Caritas

The concept of the personal doctor is also relevant in a wider context for the current medical paradigm, or model, having its origins in the nineteenth century is increasingly under challenge as it has been for long in this College (so ably articulated by Marshall Marinker) and as it was in Denis Pereira Gray's Mackenzie Lecture in 1977;<sup>8</sup> McWhinney has recently concluded that this model is no longer a tenable one.<sup>9</sup> The existing paradigm, as McWhinney acknowledges, has served its purpose well and has allowed the application of technologies to medicine. The model, however, makes little recognition of the interplay between mind and body and is largely concerned with the mechanics of medicine where the disease almost excludes the person. Not surprisingly, general practice has been the field in which that deficiency has become most apparent aided to a large extent by patients themselves who, in increasing numbers, have expressed their dissatisfaction with the conventional medical model and have been seeking help outwith it. Perhaps put another way, the mechanistic model represents two-dimensional medicine whereas increasingly we recognize the need to practise in three dimensions with all the changes in perspective and understanding which that added dimension implies, incorporating the complexity of physical, behavioural, and degenerative factors, operating with those other determinants of personality — life experience, social relationships and, most importantly, physical environment. There will always be a basis in medicine that is mechanical or what John Howie calls 'cellular'.<sup>10</sup> Insulin will continue to save the life of the diabetic, vitamin B12 will be needed in pernicious anaemia, but in other forms of disease the display of a therapeutic agent will not be enough for, while 'a heart is what a heart can do', a heart is also what a heart can feel. It has, however, taken general practice a generation to reach this point of recognition but, as Professor Margot Jefferys discovered, little fundamental change has been made, although a great deal has been written.

The difficulty of widening the horizons of general practice within its present structure was demonstrated by Jefferys and Sachs in their extensive study published as *Rethinking general practice*<sup>11</sup> which showed the range of opinion on the theme of the personal doctor held by both doctors and patients. The study concluded that while most doctors accepted, at an intellectual level, the desirability of widening horizons and providing personalized care, nevertheless they did not practise holistic medicine to any great extent. Significant numbers of doctors and patients had reservations regarding too exclusive an interpretation of 'the personal doctor' not only because of the danger of over-possessiveness on the part of the doctor towards his patients but also for practical reasons in regard to access to services. Patients want to be able to exercise personal preference in particular situations, not least the opportunity to consult a partner of a different sex or who has developed a special interest or who provides, for example, such services as a well woman or child surveillance clinic. The patient must also have immediate access at times of emergency and for certain contingencies, recognizing that the services of the whole primary health care team are available to him.

The complexity of process within this structure where the range of resources provided by the group tends to obscure the quality and potential of the relationship with an individual doctor, has provoked the response of protagonism for personal lists. At the opposite pole there are those who take the view that patients should register with a practice rather than with an in-

dividual doctor. Both policies have their merits but our aim should be both to develop the potential of the group and encourage the patient to choose a personal doctor whom he will normally see and who, knowing how he lives, provides access to unhurried consultations where the patient's problem can be considered, his general health reviewed and appropriate anticipatory care provided — thus realizing the 'exceptional potential' of the primary care consultation as defined by Davis and Stott.<sup>12</sup> Personal doctoring could be extended further if our aim was to allow each patient a review consultation in some depth with his own doctor once a year and lasting perhaps 20 to 30 minutes. It is a measure of the restricted resources of British general practice that to implement that aim would require a doubling of total consultation time as well as a proportionate increase in general practitioner manpower.

### Scientia

To shoulder responsibility as a personal doctor safely it is essential to know a great deal of medicine, to practise it consistently, and to have the respect of hospital colleagues in a wide range of specialties. As Julian Tudor Hart in his George Swift Lecture<sup>13</sup> and John Hasler in his Mackenzie Lecture<sup>14</sup> have emphasized, the process of care provided in practice varies widely in performance and there are few chronic diseases where we could with confidence guarantee patients that, anywhere in the United Kingdom, they will be as well cared for by their practitioners as they would be in attending a hospital clinic.

At present the treatment a patient receives is, in many clearly defined conditions, more related to the doctor he attends than the condition he presents. The work of Parish,<sup>15</sup> Howie,<sup>16</sup> Wilkin and Metcalfe,<sup>17</sup> but more particularly Crombie and Fleming,<sup>18-22</sup> has repeatedly demonstrated that in relation to almost every factor influencing general practice — including consultation rates, prescribing patterns, referrals to hospital, investigations undertaken — the greatest variable lies in the performance of the general practitioner himself. The implications of these findings are fundamental and indeed critical to the development of general practice as a discipline, for while recognizing the importance of allowing freedom of individual decision and style, the range of performance between practitioners is so great that either these responses are largely irrelevant or a significant proportion of patients receive inappropriate care. Where the responses of practitioners to well defined conditions vary by a factor of four or five, and sometimes more, the discipline of general practice becomes increasingly difficult to discern. Nor are the implications purely clinical for there are quite fundamental repercussions on health service economics. For example, hospital referrals from each general practitioner in 1982 led to the initiation of approximately £250 000 worth of hospital resources. However, such is the range of variability between doctors that the equivalent costs for doctors with the highest and lowest referral rates were £509 000 at one end of the scale and £106 000 at the other.<sup>23</sup> As the total prescribing costs of the average general practitioner in the same year were approximately £50 000 the difference between the highest and the lowest referral costs of some £400 000 is a matter of paramount significance, and offers a tremendous incentive to health care planners to provide general practice with the resources to encourage the maximum investigation and care of patients within the community, as well as a stimulus to general practice to audit referrals.

There is, therefore, a clear responsibility on the part of the College to develop protocols for the management of clinical conditions the plea for which has repeatedly been made by John Fry in the concluding passages of *Present state and future needs*

in general practice.<sup>24</sup> The College has been happy enough to join with paediatricians, psychiatrists and geriatricians<sup>25</sup> in defining the educational content of these specialties in relation to general practice and the time is now overdue to develop protocols for the management of clinical conditions themselves and against which performance can be measured.

For some years, under the original initiative of the Royal College of Physicians of Edinburgh, a tripartite working party drawn from that College, the Faculty of Community Medicine and our own College, has studied a range of clinical conditions to try and achieve better performance, both in practice and in hospital, in relation to investigation, diagnosis and management. At the outset 71 Edinburgh general practitioners allowed their records to be examined by community medicine specialists, who recorded the ways in which a diagnosis of hypertension was made, the treatment given and the follow-up provided.<sup>26</sup> Later a similar study was undertaken in hospital.<sup>27</sup> Both studies revealed major deficiencies in respect of quite fundamental clinical matters such as the criteria for recording blood pressure, the number of occasions on which it was recorded before starting treatment, and the investigations undertaken. The results of the working party have allowed a much closer cooperation between practice and hospital.<sup>28</sup> I believe that Honigsbaum<sup>29</sup> is right when he suggests that the clinical isolation of general practice from hospital has tended to impede the quality of care provided in practice. Diabetes and hypertension are diabetes and hypertension whether in or out of hospital and whatever advantages in terms of behavioural medicine may lie with the general practitioner, the fundamental factors in these conditions are mechanistic or cellular, and they demand equivalent responses from whatever doctor the patient chooses to attend.

### Standards of care

The College must be the appropriate body to set basic standards of performance in relation to patient care, allowing individuals or groups freedom to elaborate or to modify. Exercising this responsibility cannot simply be left to individual partnerships or groups, for while many may do so the evidence is that the majority will not and the discipline will continue to display unacceptable disparities. There has in any case been movement towards a more prescriptive approach by the College, particularly in the series of publications on prevention. *Healthier children — thinking prevention*<sup>30</sup> led directly to the joint Royal College of General Practitioners and General Medical Services Committee publication *Handbook of preventive care for pre-school children*.<sup>31</sup> One of the objectives of the College's distance learning programme, CASE, is to encourage faculties to develop protocols for the management of clinical conditions.<sup>32</sup> Certainly in Scotland collaboration with our colleagues in hospital and community medicine has been a productive exercise and led directly to the development of six-month training posts in paediatrics from a base in general practice rather than hospital but supported by specialist teaching<sup>33,34</sup> and this in turn led to the joint development of the Diploma in Community Child Health which is proving attractive for those who wish to take a special interest in child care in the community. General medicine, however, remains the most important specialist component for the general practitioner for, as the classical study in North Carolina<sup>35</sup> demonstrated, the longer a man's training in general medicine the more likely he is to be a good practitioner. Analysis of the results of the MRCGP show a strong positive correlation with performance in the MRCP and I believe the time is now opportune for approaches to be made to the Royal Colleges of Physicians with a view to reciprocity between new Part I examinations in both Colleges. General professional training would then be provided with a defined educational base.

### The constraint of time

If the full potential of personal doctoring is to be realized and with it all the satisfaction that it can give to patient and to doctor in terms of *scientia* and *caritas*, there is a further factor which is fundamental to either frustrating or fulfilling our aims and to which I have already made reference.

For a very long time patients have been telling us, in one form or another, that the thing they most want from their personal doctor is the thing that he seems least able to provide — time — time to listen, to discuss and to explain.<sup>36</sup> During our period in office John Horder and I travelled widely throughout the United Kingdom and whenever we invited members of the College, and particularly young members, to identify their principal concerns about practice, shortage of time in consultation dominated the responses together with uncertainty about the role of the College itself. Certainly three-dimensional medicine cannot be practised easily within the six minute consultation (*pace* Jack Norell), although mechanistic medicine probably can. The College has spoken with an uncertain voice on the issue of 'time' but has wisely been reluctant to conclude that a reduction in practice list size would in itself solve the problem. For me the most impressive paper on this theme remains the study by Richardson and Buchan in Aberdeen in 1973,<sup>37</sup> which showed that the average face-to-face consultation by general practitioners in Aberdeen — not a heavy industrial area — lasted less than five minutes and the recommendation of that report was that the most important advance in general practice would come from an extension of face-to-face time in consultation from five to 10 minutes. On the whole, however, I have been disappointed by the research that has appeared on this subject which seems to me to have reflected Ian McWhinney's warning against placing too much weight on numerical data.<sup>9</sup> Sufficient general practitioners, and even more patients, have provided adequate descriptive evidence of dissatisfaction — dissatisfaction derived in the main from the inability of the doctor to indulge in Dame Annis Gillie's recreation of 'listening'.

Until we define the expectations that we and our patients have from the consultation, the extent of anticipatory and preventive care to be provided, the responsibilities for chronic illness, and the clinical management of the practice with consideration for unmet patient needs, it is meaningless to place any average figure on a list size or even to quote an optimum consultation time. The general practice of the future which we are now in the process of describing and defining will require a new timeframe for its effective implementation. The job description is changing and so also will be the time and the numbers necessary to implement it. Our responsibility must surely be to free general practice from the bondage of inadequate time, a bondage which John Horder has described as 'a national disgrace', and which a retiring Professor of General Practice has poignantly equated with the description of a French military *bordello* where quality is sacrificed to speed of throughput.<sup>38</sup> 'This, more than Balint', he said, 'is our sort of world' expressing, in admittedly more vivid language, what the first Professor of General Practice called the 'qualitative/quantitative dilemma' of British general practice. It is a dilemma which makes an immediate impact on any visiting doctor from a developed country but the College has never fully appreciated the implication for general practice of that dilemma perhaps because those who experience it most have had the least time to serve on College Councils.

Critical to the factor of 'time' and to extending the dimensions of primary care will be the extent to which nursing, as a profession, is willing to enter into partnership with doctors in the community and follow the prescription so clearly set down by our Honorary Fellow and most distinguished nurse, Dr Lisbeth Hockey.<sup>39</sup>

### The epidemiology of practice

Lifting now our sights beyond personal doctoring, one of the most important developments in general practice in conceptual terms, if not in application, has been the recognition of responsibility not only for individual patients but for populations of patients in respect of their health, their clinical care and the opportunities the population presents for research. It was Mackenzie in a letter to his young cousin Andrew Garvie<sup>10</sup> (no relation to our current Honorary Treasurer but an ancestor of John Garvie Howie who succeeded Dick Scott in the Mackenzie Chair of General Practice in Edinburgh), who first defined epidemiology in terms of non-infectious disease. In his letter to Garvie in 1920 referring to Garvie's studies in general practice for the purpose of gaining an MD, Mackenzie wrote 'Moreover it has put you upon a line of observation which is much required and by similar observations on other diseases you will throw a flood of light in dark fields ... and you need not limit your observations to epidemic diseases' — by which he meant infectious diseases.<sup>41</sup> In this Mackenzie recognized that the general practitioner had unrivalled opportunities for the study of non-infectious disease in epidemiological terms. Mackenzie, when he retired to St Andrews, intended to study disease in a controlled population with a view to its prevention. Although the project was over-ambitious and Mackenzie was already unwell, nevertheless he laid the foundation which has led to the major epidemiological research studies which I believe are 'The jewels in the crown' of this College in direct extension from the work of Mackenzie and the achievements of Pickles in relation to infective hepatitis and epidemic myalgia. (There is incidentally an interesting link between Pickles and Mackenzie for Pickles' wife, Gerty, who played such an important part in his work came from Burnley where she was delivered as a baby by the family doctor — Mackenzie.) If Mackenzie and Pickles recognized the potential of the general practitioner for research into the population he serves and in the light of the triumphs of the College's Research Units directed by Donald Crombie and Clifford Kay in Birmingham and Manchester, it is surprising, if not scandalous, that the College has failed to build on that success and realize the potential for a major research unit providing data over the whole field of health and disease in the community. Such a unit would be unique and its data of incomparable value to clinicians, researchers, health care planners and, importantly, in respect of the safety of medicines.

### Management

The genius of Mackenzie in extending the concept of epidemiology beyond infectious disease led to his ambitious project in St Andrews bringing together general practitioners, in financial competition, to work from a common clinic, and was a brilliant exercise in 'management'. Practice management and practice managers are now accepted parts of the administration of practice. This development requires, however, to be seen together with concepts of clinical management of populations and the time has come to incorporate both as integral parts of the responsibilities that fall on every general practice. I use the words 'general practice' deliberately because acquiring the skills to which I refer will need a special training and the assumption of responsibilities which need not fall on every partner in a practice. The single-handed practitioner will need to be aware of them, but they become increasingly important as the group enlarges and are essential if doctors work in association with colleagues in nursing, health visiting or other associated disciplines. Equally important is the effective employment of technological advance illustrated by the microcomputer. In his William Pickles Lecture of 1977,<sup>42</sup> Michael Parry states: 'The growth of scientific and technical knowledge and the increas-

ing size of organizations has led to the realization that "management" is a necessary skill and a discipline for which there is a body of knowledge that can be taught. Management is not simply a matter of commonsense.' The failure of 'the team' in general practice to realize its potential arises directly from the failure to appreciate the importance of management and above all to allocate the time and resources to the process of management by at least one member of each partnership in practice. The efficient and effective care of patients with chronic disease, the application within the practice of national policies in respect of preventive medicine, the operational integration of doctors, nurses, health visitors and administrative staff, the financial efficiency of the practice, are all matters that require skilled direction and at present are too often dealt with cursorily by doctors or left as the responsibility of practice managers. Practice managers play a vital role within this area but they should be senior executives and not managing directors.

It would be consonant with our heritage from Will Pickles if every practice were to assume responsibilities for its practice population that were formerly those of the Medical Officer of Health. It was his responsibility to produce an annual report with data on the state of health of the population for which he was responsible, to identify areas of concern and to attempt to meet identified needs. Ultimately he was held responsible for major preventable deficiencies in the health status of the population. All of these responsibilities have a direct parallel in practice today and the role of the College must be to define the content of community medicine as an integral part of modern general practice. General practice needs its own 'outreach' into the discipline of community medicine.

### Inequalities in health

The publication of the Court Report<sup>43</sup> marked a milestone in an appreciation of tasks facing this country in relation to the care of children. The College's response<sup>44</sup> led to the development of a policy on preventive aspects of child care set down so effectively in the College's publication, *Healthier children — thinking prevention*.<sup>30</sup> The Court Report, however, was succeeded by the even more important Black Report on *Inequalities in health*<sup>45</sup> and this appeared during my period of Chairmanship of Council. I hold myself responsible for the fact that, in spite of David Metcalfe's encouragement, the College failed to respond adequately to the implications of that immensely important Report. It showed, for example, that at birth and in the first month of life twice as many babies of unskilled manual parents die as do babies of professional class parents and in the next 11 months four times as many girls and five times as many boys. If the mortality rate of social class 1 had applied to classes 4 and 5 during the period 1970–72 10 000 children would not have died. The lack of improvement, and in some respects deterioration, of the health experience of classes 4 and 5 relative to class 1 was strikingly demonstrated. The Report provocatively concluded that 'the evidence suggests that working class people make more use of general practitioner services for themselves (though not for their children) than do middle class people, but that they may receive less good care.' This statement has, of course, been challenged by Crombie.<sup>46</sup> But Black went on to say 'It is possible that this extra usage does not fully reflect the true differences in need for care as shown by mortality and morbidity figures.' Like the Court Report the Black Report showed that the British record compared decidedly unfavourably with Scandinavian countries and the Netherlands, although broadly similar to Germany. The report drew attention to the substantial improvements in infant mortality in France during the 1960s by efforts to secure higher attendance rates for antenatal care and through higher quality of that care. The Report, of course, acknowledged the

multi-causal nature of health inequalities and the dominant influence of social circumstances, which would now include the effects of unemployment on health, but concluded that early childhood is the period of life at which intervention could most hopefully weaken the continuing association between health and class and agreed with the Court Committee's comment that 'Inadequately treated bouts of childhood illness cast long shadows forward.' Yet in 1982 the Scottish county of Fife reported as many cases of measles as the whole of the USA.<sup>47</sup> Most importantly from the point of view of general practice the Report recommended that resources should be based on need. The difficulty in assessing need was recognized but it was felt that indicators of health care and social need at district level could, and should, be developed urgently. The report argued that a shift of resources was not in itself enough; it must be combined with an imaginative approach to health care and its delivery with the distribution of general practitioners, for example, related not only to population numbers but to medical need derived from health care indicators.

The failure to respond to the invitation contained in the Black Report to suggest imaginative initiatives in respect of the delivery of primary care in this country is difficult to understand but I hope that this is an omission that can still be corrected. College policy, for example, supports the recommendations of the Royal Commission on Medical Education<sup>48</sup> and a five-year period of vocational training<sup>49</sup> where the initial three-year period would be followed by two further years in general practice itself. One way of implementing that recommendation and increasing the medical resources in underprivileged areas would be to invite, or require, a young doctor to spend two years of further professional training as the equivalent of a senior registrar in general practice attached to practices in areas of social deprivation. This would provide invaluable training and experience to all young doctors and might help to make some provision for unmet need. Above all it would show that we recognize that medical resources require to be distributed on the basis of need and not simply of numbers.

### The oasis

In conclusion, the role of the College as an oasis is an important one, for after long journeys in arid territories the College at Princes Gate provides a sanctuary from which I have never failed to return refreshed and stimulated. Friendships formed in my own faculty and indeed in faculties throughout the United Kingdom and the Republic of Ireland have added a major dimension to my life and over the years at Princes Gate I have been privileged to meet and to know most of the people who have significantly contributed to the development of general practice as a discipline. The ability to stand aside from the day-to-day pressures of practice and cast a longer perspective in the company of friends whose qualities of character and intellect I have respected has been a rewarding experience. But as Sir George Godber pointed out in his 1985 William Pickles Lecture,<sup>50</sup> Florey and Chain were as important as Fleming in the story of penicillin and the quality of care of patients will not be advanced unless ideas and concepts can be crystallized in ways that not only convince us of their merits, but are implemented. After his Lecture, in congratulating Sir George Godber, I said to him, 'I only hope that the College can convert these ideas into action.' He replied 'If the College can't — nobody will.' The College must therefore be both oasis and beachhead.

President — we can approach the future with confidence and enthusiasm if we ensure that the richness of our inheritance is allowed to influence, but not direct, our successors. The game is still afoot, the stakes are high, very many prizes remain to be won, provided we can display the same courage and imagination shown by the men who founded this College.

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### Epstein-Barr virus

In a recent review the cellular events underlying Epstein-Barr (EB) virus infection in man are considered in respect of three situations. Firstly, the events of the primary infection leading to infectious mononucleosis are described and illustrate the multiplicity of virus-cell interactions and of immunological responses involved. Secondly, possible mechanisms to explain EB virus persistence in the virus-immune host are discussed in the light of new studies monitoring the various indices of the virus carrier state. Thirdly, the analysis of EB virus infection in immunosuppressed patients shows how a relaxation of T cell-mediated immunity alters the position of the virus-host balance.

Source: Rickinson AB, Yao QY, Wallace LE. The Epstein-Barr virus as a model of virus-host interactions. *Br Med Bull* 1985; **41**: 75-79.

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