general practitioner, struggling towards a weary old age with no secretarial help, no intellectual refreshment and no contact with colleagues, is now a member of an endangered species, confined to the game reserves of our inner cities or, more idyllically, to the remote valley or glen so beloved of medical teachers as the hypothetical scene of sundry emergencies.

These are a few of the reasons which make me feel secure about the future of general practice, and also proud to be a Fellow of the Royal College of General Practitioners. But you may by this time be saying: Is this some visitor from another planet who knows nothing of our difficulties and uncritically admires all the developments which have taken place? So let me conclude this cursory glance over general practice by expressing one or two concerns, which may or may not be well-founded.

Vocational training for general practice recognizes that it is one of the more demanding specialties; and attention is rightly paid to the importance of communication, to high ethical standards and to efficient practice management. Moreover, my greatly esteemed Manchester colleague Pat Byrne was among those who encouraged us to learn the lessons offered by educational experts. These things are good, but like all good things they may compete with other good things; and I have sometimes worried lest pedagogy and packaging might be taking precedence over the core of practice, which is the corpus of knowledge which predominantly, though not of course solely, distinguishes us from the unqualified practitioner.

The only other worry with which I have space to trouble you relates to what may be a neglected opportunity. I do not know whether our cash-limited, re-re-reorganized and now overmanaged health service is still the envy of the world; but with its high coverage of the population it is still the envy of the world's epidemiologists. Will Pickles showed the way so many years ago; but I would like to ask, as Julian Tudor Hart has done, whether we have been faithful in following it. Of course, social mobility has increased greatly since Will Pickles' day; but even if it is less stable, a general practitioner's list is still a defined population, giving a unique opportunity for preventive medicine and, what is quite as important, for assessing the efficacy of particular measures.

Alma-Ata

At the risk of allying myself with Mephistopheles — *'Ich bin der Geist der stets verneint'* — and being a curmudgeon to boot, I have two reasons for suspicion about the Alma-Ata declaration, and the relevance of general practice to it.

Of course, great things have been done, and will be done, in the conquest of disease; and the WHO, under Dr Mahler's leadership, has played a notable part in such things as the eradication of smallpox and the intensive campaign against tropical diseases. All credit to them, but is it really realistic to suppose that there will be no residual health problems in 14 years' time? So my first ground for suspicion is the total lack of realism in what purports to be a proposal.

My second doubt relates to the relevance of general practice as we know it to the attainment of better health world-wide. In the WHO formulation, the goal is to be achieved 'by primary care'. I find this terminology misleading, for what seems to be meant by 'primary care' has little to do with the practice of individual medicine (still at the core of our family practice), but rather with clean water supplies, adequate and sound food, eradication of vectors and parasites — vitally important matters but not ones closely related to family practice in this country.

To sum up, in this country, which I hope will stay 'developed' and not be turned into a post-nuclear wasteland, we shall not want or need bare-foot doctors; what we shall need, into the indefinite future, are doctors who are both caring of the whole person, and also competent technically and scientifically — in other words, good doctors. And we shall continue to need them, as we already have them, both in general practice and in the specialties.

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General practice 2000

IT is five years since my predictions for 2010 were published in the *Journal*.[1] The invitation now to shorten my vision to the year 2000, gives me the chance to revise my views and to urge caution.

In my earlier paper I was concerned with the impact of the new technologies, notably robotics, and the information technologies on society, and the implications of these accelerating changes for the practice of medicine. Here I have to reflect further on the nature of change and the challenge to general practice.

The sudden advent of the epidemic of acquired immune deficiency syndrome ought to provide us with a sharp reminder about the nature of change. An alteration in the behaviour of a virus, or of a particular community, can at any moment turn society upside down. Our response to this disease seems to me to mirror nothing so much as the response of the stock exchange or the money market to the news that a national football team has lost a game, or that a secretary of state is having a love affair. The cataclysmic alterations in the value of shares or the exchange rate of a currency results not from rational economic appraisal, but from a mass emotional response. What was missing from my earlier appraisal of the future of general practice was the recognition that in reading the cards it is unwise to forget that there are jokers in every pack.

Futurology, then, is concerned not only with the march of technology and the effects of that technology on society, but also with the operation of the unpredictable. Nor is that the end of the story. The next history of general practice, like the last, will be shaped not simply by forces beyond our control, but by ourselves.

It is the will of men and women which brings about change and more importantly their imaginations. On the grand scale of life, my experiences are confined within the imaginations of Plato and Darwin, Einstein, Freud, Mozart and the rest. On the more humble scale of professional life, I recognize that contemporary general practice was created out of the imaginations of Beveridge and Bevan, Mackenzie and Pickles, Cronin and others too recent to name here. This awareness of the primacy of people over historical forces, permits me not to prophesy, but to hope and to urge.

It would be easy, but erroneous, to predict that general practice in the year 2000 will result simply from a linear extrapolation of our current preoccupations. For example, there is a drive to convert the patient into a consumer. This may distract us from the need to encourage a sense not of consumption, but of citizenship. The notion of consumer in Western society is inextricably linked with the role of adversary. In contrast, a citizen has both rights and obligations. A practice population of citizens, in con-

trast to a population of consumers, may be capable of taking part in a health caring community, in which both doctors and patients are cared for.

Because of the power of modern medical intervention, and because of the increasing sophistication of the public, there is a shift of emphasis from intraprofessional to public accountability. Performance review is becoming an integral component of professional status, and more recently performance review has been suggested as the only sensible basis for calculating the financial rewards of doctors. Public accountability, the drive to audit and the achievement of a performance-sensitive contract will undoubtedly give both the profession and the public a sense of order, and a measurement of quality. But there may be an over emphasis on what is measurable in medicine. However important the components of medical care which can be measured, what is unmeasurable (respect for the individual, compassion for suffering, tolerance of the idiosyncratic) remains equally important. These unmeasurable qualities may, in the last analysis, only be reflected in the rights of the individual patient to choose his own doctor, from a variety of doctors. The availability of real choice of doctor, however, is in conflict with another of our current fashions.

Over the past 20 years, we have seen the emergence of large partnerships, group practices sharing extensive premises, and groups of individuals working together from a variety of professional backgrounds in nursing and social work. The drive to larger group practices peopled by multiprofessional teams, carries with it all the advantages of sharing human and technical resources. But with it come the disadvantages of a corporate approach to the concerns of unique individuals. Large partnerships may move only at the pace of the least imaginative, the least reformist and the least committed of the members of the group. Team-work can easily result not in the deployment of a variety of professional skills, but in the loss of a personal relationship and confusion of professional responsibility for which Balint coined the phrase 'the collusion of anonymity'.

Today there is a marked shift of emphasis in much of the literature of general practice, from so called re-active to pro-active care. The general practitioner is increasingly urged towards prevention and early intervention. Such a preoccupation may appear to be entirely benign. But it can also distract the doctor from his traditional task: the response to the individual who believes himself to be ill. The word 'patient' is a half word, like 'lover' or 'confidante'. It describes half of a relationship.

Too radical a shift towards anticipatory care can easily erode the boundary between person and patient. The patient as citizen has the right to decide himself when he needs medical care, and to accept or reject the advice for which he has asked. Because general practitioners are generalists, they have enormous difficulty in rejecting new tasks. At one and the same time, we currently ask general practitioners to care for unique individuals and whole populations. We ask them to be pro-active in health education and prevention, and at the same time to practice clinical medicine with a sensitive regard for the autonomy and independence of their patients. It could just be that some of these tasks are inimical.

At the time of the Collings Report,[2] general practice was described as a cottage industry in this country. But industry only moved out of the cottage because of the drive of industrial technology. There was no human imperative to invent the factory or the office block. In our post-industrial society, we may well redesign the cottage and reinstate the industry — or at least a service industry like general practice. Many future general practitioners, in response to changes in technology and society, may well choose single-handed practice, and relocate their consulting rooms to their own homes. It will not be beyond the scope of the new technology to provide all the necessary resources, not least the resources of communication on which the highest quality of medical care will come to depend.

Let me summarize. My most confident prediction about the future of general practice is its unpredictability. I suspect that in a world of accelerating change, the biotechnology of each decade will little resemble the biotechnology of the previous decade. Communities may form and reform in a dazzling kaleidoscope of social invention. In such a world, it will be the ethical issues, the penetrating study of the human values on which our actions are based, which will provide medicine with its guidance system.

I cannot resist a passing comment on the role of contemporary institutions in such a future world. Sooner rather than later, the impact of the new communication technology will call into question the utility of many of those major institutions which up until now we have taken for granted as the reference points of contemporary general practice: the district general hospital, the university medical school, even the national royal colleges themselves. In their place, we will need to invent smaller and more local groupings, capable of fast communication and rapid adaptation to new challenges.

By the year 2000 we may see the emergence of a new diversity of primary medical care, a new concern for the human scale of practice, a new sense of the intimacy and privacy of the doctor–patient relationship, and a new sensitivity to the infinite variety of human beings. General practice may come to be based on single-handed practitioners, perhaps loosely confederated in groups which will share managerial and technical resources. It is even possible that male doctors will finally come to embrace the equal partnership of women doctors. But not perhaps until they have come to terms with the feminine half of their own natures, and the feminine component of medical care.

The next generation of general practice leaders have only to imagine it.

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All good doctors should ...

THE 1960s saw the re-emergence of general practice from the dark days when morale was low and the future bleak. In the 1970s general practice grew in self-confidence and influence and perhaps the early 1980s have seen complacency in some practitioners. However, recent proposals for change suggest more things for the general practitioner to do and there is a tidal wave of commitments waiting to engulf those who may already feel overwhelmed by the daily routine. An article about health care in modern society by the vice president of one of the major medical centres in the USA listed over 20 items which he considered to be at the forefront of medical care: birth control, genetic manipulation, euthanasia, physical disease, poverty, nourishment, psychological trauma, narcotics, alcohol, venereal disease, accidents, violence, suicide, boredom (from both leisure