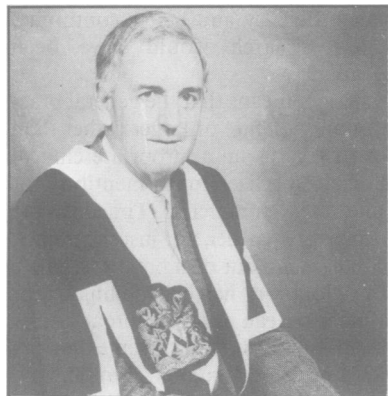


Clinical medicine and the health divide

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Introduction

MY mother-in-law and father-in-law live happily together in Summerseat Lane, Holcombe Brook, near Bury in Lancashire. The address of the speaker's mother-in-law must surely be the most inauspicious piece of information with which any Mackenzie lecturer has ever begun. But you will see the relevance when I tell you that I set out this year on a biting cold January day from Summerseat Lane which leads down to the tiny Summerseat railway station. It was through here and through an unpoetic jangle of other Lancastrian stations — Bowken Vale, Besses O' the Barn, Ramsbottom and Rawtenstall — that Dr Mackenzie travelled from Scotland via Manchester to Burnley in August 1879 to begin his 29 years as a general practitioner.

Like most of you reading this lecture, 12 months ago I knew virtually nothing of James Mackenzie, hence my pilgrimage to his town. As a result of that visit and my study of two inordinately dense biographies about him — I commend them heartily to future anxious Mackenzie lecturers as an alternative to temazepam — I now know a great deal more.^{1,2} James Mackenzie practised in an elegant 'corner shop' Regency building for 29 years. Above all he was a great clinician and it is not surprising that the Burnley Postgraduate Centre is named after him. I suppose he must have looked something like Luke Fildes's 'The doctor' (Tate Gallery) — intensely observant, inordinately compassionate, but alas therapeutically impotent — so well perceived by the distraught parents in the background.

Nevertheless his accurate history taking and observation of simple things like the pulse, the neck veins, the apex beat, the respirations — continuously and meticulously recorded in the same patients over 29 years — coupled with the use of his self-designed polygraph, enabled him to describe the natural history and prognosis of atrial fibrillation, ventricular extra-systoles, sinus arrhythmia and the action of digitalis. He was always particularly proud of the work which he did in identifying benign irregularities of the heart, which since the invention of the

stethoscope had often resulted in the invaliding of perfectly healthy people. He used the expression 'a heart is what a heart can do'.

It was these clinical discoveries in the back streets of Burnley that formed the nucleus of his work when he became a Harley Street cardiologist. But why did he leave general practice when he was achieving so much? His biographers say he needed the stimulus of more esteemed colleagues with similar enthusiasms for clinical work; he himself described general practitioners as 'the humblest members of the profession'. As a general practitioner his hours of work were much too long, he was seeing too many patients per day and he was doing too many home visits. In his own words 'I shall leave the drudgery and aim at higher things'. But now a 100 years later does it not all sound just a little bit familiar?

Have matters changed? Are we now able to do the stylish clinical medicine and even research that Mackenzie felt was ultimately impossible? Bright people in those days left general practice to specialize — these days they still leave, only now they are promoted to university departments of general practice, or head drug firm foundations, or go into medical administration, or even become regional advisers. But perhaps more importantly many do not leave, but are unhappy staying and find that like Mackenzie, day-to-day service general practice lacks the continuing academic, clinical and intellectual challenge necessary to satisfy them.

Modern general practice

James Mackenzie was one of a two doctor practice — the majority of general practitioners are now in groups of four, five and six, so we are rid of the professional isolation, and now rub shoulders with like minded people, challenged and excited by the same clinical problems. That former atmosphere of benign, genial avuncular, camaraderie should have changed to a more academic, stimulating, rigorous and even argumentative environment. But how often has the temperature risen recently in your surgery from heat generated by clinical debate? In ours we only argue about the telephone system.

We should all now have excellent premises — we have had ample opportunity from grants and rents. But above all we should be members of sophisticated teams of caring fellow professionals. James Mackenzie had never heard of the primary health care team — he would certainly have failed the MRCP examination. The team is no longer the old style doctor/nurse/receptionist group of the mid 1960s, nor the one of the late 1960s and early 1970s that was increased by reimbursement of the wages of the staff and expanded by the attachment of community nurses, midwives and health visitors — but nevertheless still a narrow clinical team. By the mid 1970s broad links with social services had been developed but the team still operated as a professional hierarchical (frequently male) chauvinist piggery.³ In the second half of the 1970s patients and their problems became the focus of an increasingly democratic mix of caring fellow professionals and today the team consists of cleaners, clerks, record analysts, receptionists, secretaries, computer staff, community, psychiatric, school and practice nurses, social workers, health visitors, dieticians, geriatric visitors, midwives, counsellors, an occasional statistician, a peripatetic clinical medical officer, an architect, an accountant, church ministers, a solicitor, not to mention the general practitioners and their trainee. It is not surprising therefore that the

The 1987 James Mackenzie Lecture was delivered at the Annual General Meeting of the Royal College of General Practitioners held on 14 November 1987 in Kensington Town Hall. *Author's note:* this lecture was prepared over a period of 15 months for spoken presentation. It contained 22 data slides, 58 photographs, nine grand master paintings and three cartoons. An amended text is presented here.

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practice brochure has become essential as a guide to team care and now runs to its second edition.⁴

But now we doctors must be prepared to release our hold on many non-clinical areas that have previously absorbed so much time and let them be dealt with by experts. Health visitors look after babies on a day-to-day basis and monitor their development, social workers take on social problems, counsellors deal with marital, inter-personal and drug dependency problems — all increasing their expertise in their disciplines, just as we should in ours, and each member of the team working to their maximum potential.

The day-to-day running of the practice must increasingly be undertaken by practice administrators reporting once in a while to a partner. In our practice apart from the busy daily team meeting over coffee we have approximately six formal working lunches per month, frequently attended by all the doctors and at five of them organizational, administrative, operational and financial problems are discussed and sadly at only one do we actually talk about clinical medicine. We must change all this in 1988.

For Mackenzie good continuous recording was the key to improved care. Lloyd George envelopes have blighted our clinical record-keeping. The College should persuade the Department of Health and Social Security to provide A4 folders and their excellent inserts to all practices.^{5,6} For with the records once organized, with summary and family history sheets opposite clinical notes and with preventive health care sheets in full use day-to-day care is improved beyond belief and the way is open to computers, analysis, recall, research and so on. Once organized, none of this, including the clinical summaries, need be done by doctors, but by appropriately trained lay staff.

I cannot leave the team without emphasizing the increasing importance of the nurse's clinical role. The modern practice nurse shares the care of chronic clinical problems according to protocols. In her 'vascular clinic' she helps with the investigation and continuing care of hypertensive patients and those with angina and heart failure; and runs her own 'diabetic clinic' with a partner to report to. She also welcomes new patients to the practice and updates their preventive care according to age and needs.

Patients themselves need to be involved and the patients' participation group, unheard of in Mackenzie's time, is becoming important and is spawning self-help groups for asthmatics, people with psoriasis and so on. Practice newsletters are beginning to keep patients informed (Thornham JR, personal communication).

But Mackenzie was bogged down by what he called the 'drudgery' of general practice. I suppose he meant what we call 'minor illness'. By promoting the philosophy of self care, by stringent prescribing and by the use of a 'minicopoeia' the huge load of self limiting illness lessens and self care increases.^{7,8} And if a doctor does not prescribe then a nurse, health visitor or midwife can advise and share the load.

In our practice we have come to terms with the fact that many consultations need last only a minute or two. Indeed, which practice in its heart of hearts has not? None of us need be ashamed by seeing familiar patients rapidly if the diagnosis is easy and the condition not serious. There is not a psychosomatic problem lurking under every ache, pain or respiratory infection. James Mackenzie said 'often enough three minutes will suffice' when he was working as a Harley Street cardiologist in private practice. All practices have found the number of time consuming home visits falling — about 18 a day in mine in the 1960s but only about six per day now, and half of them done by nurses.⁹⁻¹¹ The residual visits are a vital, essential and lovely part of general practice and abound with clinical content — the

care of the dying, the magical alleviation of bronchial or cardiac asthma, the prompt life-saving pain relief in myocardial infarction, the monitoring of the chronic housebound elderly sick.

In our practice we find personal lists important, partly because of the low number of doctors contacts — about two per year compared with the national average of three or four.¹²⁻¹⁴ But personal lists give us greater efficiency and better continuity, without which Mackenzie's research would have been impossible¹⁵ and so would mine.

So the result of all these changes means that the general practitioner has time. Time for quality of care of larger rather than smaller lists — 3000 seems to give us an appropriate clinical volume for maintaining clinical expertise, not to mention providing adequate teaching and research material. Time also for a study half-day every week for every partner, not just the trainer, in which to think, read and research in our own practices. There are splendid examples of this. John Fry has been telling us for 25 years that we overuse antibiotics in ear, nose and throat disease — we still do though.¹⁶ Julian Tudor Hart has been exhorting us for 10 years to check blood pressure regularly in middle aged patients to prevent premature stroke — we forget though.¹⁷ Aubrey Colling has proved that home care of patients with myocardial infarction is as safe, if not safer, than coronary care units — we usually send them in though.¹⁸ And Ian Gregg has been using and promoting the peak flow meter for about 15 years — but we do not use it very often.¹⁹

General practitioner obstetrics

Let me continue the sorry tale of unimplemented general practice research by talking a little about obstetrics.²⁰ Between 1962 and 1987 I cared for 1185 pregnancies with a perinatal mortality rate, including those referred for specialist delivery, of 9.2 per 1000 births. This compares very favourably with the figures for England and Wales falling from 29 to 9.6 and for Stockton falling from 36 to a statistically insignificant 6.5 over the same period. Since 1980 every partner in the practice has audited his care and for the last 1387 consecutive deliveries the perinatal mortality rate for the whole practice has been 8.6.

The results are really pretty good and are a credit to the whole team and to the 'specialty' of general practitioner obstetrics, supported by hospital colleagues who have managed well the more difficult problems which we have carefully assessed, cared for and filtered through to them.²¹ Nearly 12% of my mothers booked for home delivery over the 25 years and 67% for delivery in a general practitioner unit — a total of 79% and of that total, 63% actually delivered under general practitioner care. Home deliveries have now virtually stopped and all our mothers are delivered in a nearby modern maternity hospital of which the second floor is the general practitioner unit.

Let me try and analyse why general practice results are so good and use my practice as an example. The surgery has been there over 100 years and is very much part of the community and near the homes of the people. It is permanent and accessible. We try to be nice to our patients and with an obstetric potential in mind particularly to the little girls when we see them with their tonsillitis, their asthma and their abdominal pains. And even more so when the shadow of their impending sexuality hangs over them and they stammer out the problems of their menarche, their dysmenorrhoea, not to mention their covert requests for contraception. Support and sensitivity through this phase by a long time physician friend means that when they do become pregnant they are very happy to come and tell us about it. For after all we may even have delivered them.

The specialty of general practitioner obstetrics offers continuing and personal care — especially when each doctor has his

personal list of patients and is supported by a comprehensive team.²² We promote contraception as a major part of our health education in all appropriate consultations and in much waiting room literature. The practice family planning nurse does the great majority of the consultations and works by protocols established at team meetings.²³ From these the preconception clinic emerged.²⁴ We have, we hope, a humane attitude to requests for abortion and this coupled with a positive approach to contraception must mean that the proportion of wanted pregnancies in our practice is higher than the national average. We know that the national perinatal mortality rate among unwanted pregnancies is high, so those missing pregnancies contracepted or occasionally aborted could be another tiny contribution to the good results.

With our detailed knowledge of our mothers we can give care where it is needed and can precede the hospital in the introduction of modern clinical routines — urine cultures and blood sugar levels are two recent examples. But what about deliveries in an era of high technology? In our practice the normal off-duty rota excludes obstetrics and only operates when we are actually out of town. Thus, unlike midwives we general practitioners continue personal care into the delivery unit. But why should doctors be present at all when there is a perfectly competent midwife in charge? First, to provide continuity and confidence. Secondly, to confirm normality with the midwife. Thirdly, to take responsibility for minor abnormalities. Fourthly, to be responsible for specialist referral if indicated. Fifthly, to support the relatives who are often patients also. Sixthly, to assess the bonding. Seventhly, to provide an extra pair of skilled hands in an emergency. Finally, because we enjoy it. So we attempt to put in an appearance at each stage and succeed in being present at almost 90% of labours.

But there are some disappointing figures from the audit. There has been a steady decline in my bookings from almost 90% in the 1960s to an all time low of 71% between 1982 and 1987, with consultants accordingly booking more and more. Recently only about 54% of patients delivered at the general practitioner unit; but at least the figures seem to have levelled out. Concomitant with increasing specialist care has been a steady fall in the percentage of spontaneous vertex deliveries from 92% in the 1960s to only 76% now. It is a sad reflection on modern obstetrics that almost one in four babies are 'extracted' from their mother in some way or other.

General practitioners in their units have battled continuously and ultimately successfully against the apparently irreversible swing to technology in the 1970s. We encouraged a good deal of the first stage of labour at home using the community midwife. We allowed our mothers to be up and about in the first stage, watching television, listening to music, reading in a rocking chair, not assaulting them with enemas and shaves and electronic fetal monitors, and of course allowed a companion throughout the whole process, including at forceps delivery. A confident and reassuring midwife was vital, and a known general practitioner coming in from time to time a tremendous boost. We advocated minimal use of drugs, especially pethidine, reserving epidurals for indicated cases. And no intravenous drips if possible since the benefits afforded to a few ketones were totally erased by the obligatory supine position of the woman which slows down dilatation and sets in train a series of abnormalities.²⁵ We looked askance at the impossible time scales to which women in labour were expected to conform. If I can give you an analogy: 'a labourer is what a labourer can do.' The woman should decide in which position she wishes to deliver. Modified squatting is the most popular and allows greater pelvic splay and greatest perineal stretching but there are countless alternatives. Episiotomies were avoided unless really indicated.²⁶

Michael Bull, a general practitioner in Oxford, has substantiated all this statistically — low risk women booked for general practitioner care had fewer inductions, less accelerating and fewer forceps deliveries with better Apgar scores and fewer babies sent to special care than a strictly comparable low risk group having specialist care in the same hospital.^{27,28} The Oxford specialists have now implemented the findings of the general practice research so that the results of normal cases under their care can improve to the general practitioners' level (Bull MJV, personal communication).

The health divide

James Mackenzie was not only a great clinician, he was also a socially concerned doctor. He wrote a novel, *Mary Helm*, about a deprived Lancastrian woman, of which his biographer states 'he brought his clinical mind to bear on a social problem and diagnosed a sick society'. The memorial to him in a Burnley Park doubtless commemorates that, as well as his clinical expertise.

It is my intention in the final section of this lecture to blend together his clinical skills and his social concern and again I must resort to my own grimy northern town, my only data base. Equidistant from my surgery are two worlds — one an estate of extremely poor standard, housing deprived people, and the other an affluent middle class area. Many general practitioners have practices with similar contrasts. In a recent survey, one of the residents of the deprived area, when asked about it, exclaimed 'It's the dirtiness of it. It has been degraded into nothing. You cannot move for broken glass. I am ashamed to tell anyone where I live now. The dogs and children are out of control!'²⁹ Of those living in the deprived area 52% were in social classes 4 and 5 compared with 23% in the UK; 12% were officially living in 'overcrowded' conditions, three times as many as the UK; 22% were single parent families, five times as many as the UK; only 16% had access to a car or van compared with 64% nationally; 56% were unemployed while the figure for UK was 12% and of those unemployed 81% had been unemployed over one year and 35% for over five. Awful statistics from a typical northern deprived estate.³⁰

We took every patient of ours living on that estate and age/sex matched them with a control in the middle class area.^{31,32} Our 587 deprived patients had significantly more physical illnesses and three times as much mental illness as the controls. Listen to a resident: 'My wife has bad nerves from living round here and that makes me bad too, I've lost a lot of weight. We're desperately after a move to somewhere we'd feel safe.' And from a woman aged 19 years: 'I've had the back door kicked in a few times and living on my own I am afraid that it might happen at night. I sit and cry a lot. I just fear living alone with two young children'. There were half as many hospital admissions again and more attendances at accident and emergency departments for all age groups in the deprived area.

So Mackenzie's social problems live on. What can the general practitioner do? Our data helped us to realize that this is a sick and sickened community — they need more attendances and visits. And they need more time in a consultation: it takes a little longer when you have got to bridge a communication gap with someone of a different class to yourself, from a totally different environment. But how did the town general practitioners in general score in the social survey: 'The doctor was not interested in my problems' and 'He just gives a prescription and doesn't listen to the problem' and 'He just said it was my nerves and told me to take it easy'; but 'The doctor is kindness itself, he knows me well and knows how to help, he comes out to see me' — if only that might have been me.

Our whole team began to fling itself at this sick community. Our data heightened everyone's awareness. Different rules were

adopted at the reception desk. It is the confused, inarticulate, apparently rude deprived families with children that should be fitted in to a fully booked appointment system — not the polite lucid middle class mother who has just popped down in the car. Infants aged under one year from the deprived area should be seen regardless of when they present and stringency with regard to home visits should not apply to them.

And from a clinical viewpoint there are things to be done: more intensive care and frequent re-visits of their sick children. Recall requests are unreliable via vandalized telephones, no transport and low educational levels. We must be ready to admit to hospital more quickly. Pride in home care must be tempered when dealing with deprived families. It would be nice if they received hospital visits from their own doctor and I am sure Dr Mackenzie would have visited them. Nurses and doctors should pay home visits following hospital admissions after conditions like myocardial infarction, cholecystectomy and menisectomy. And after ordinary illnesses like influenza, bronchitis and gastroenteritis, it might be worthwhile giving vitamins and iron; certainly more frequent measurements of haemoglobin levels have given me some nasty surprises.

The data from the eight year pregnancy audit of the whole practice shows that 42% of those in social classes 4 and 5 were single at conception compared with 5% of social classes 1 and 2; 45% smoked through pregnancy, compared with only 13% of social classes 1 and 2; and only 18% are breast feeding at six weeks compared with 60% of social classes 1 and 2. So those in social classes 4 and 5 need more attendances at the antenatal clinic, and we have re-structured the specialists' out-of-date conventional programme to discriminate positively in their favour.³³ They also need automatic referral to social workers and health visitors at the beginning of pregnancy. They need more meticulous scoring of their bonding with their babies; non-accidental injury, often predictable at birth, is not uncommon in our deprived area.³⁴ They need more team home visits on return from hospital and their six week postnatal examination should be rigorous.

Their fertility rate is relatively high: the 28 16–19 year old deprived girls had 16 babies, while the controls had none. The 111 older women had two and a half times more babies than the controls. This high fertility was despite the fact that 80% had their contraception recorded in their clinical notes — better than the controls.

So the clinical challenge is considerable and we must remember it and discriminate to meet it. We must also be positively eager to support financial requests for social necessities that can well help clinical illnesses. For example, washing machines for enuretics, the electricity reconnected for small babies, roller blinds instead of curtains for asthmatics, mixer blenders for dying cancer patients and extra money for high iron diets when the haemoglobin levels of children and mothers are low. And the whole time social workers and health visitors must be aware of what we are doing so they can follow it through.

Preventive care

But what has general practice to offer in the field of prevention? Well man and well woman clinics are now commonplace but in 1984 in our practice it was mostly patients in social classes 1 and 2 that were making appointments for them.^{23,35} Although there were no differences in the levels of tetanus immunization, blood pressure recording or urine testing between the social classes at that time, the absolute figures were terrible — 38% of men had a blood pressure recorded in the last five years and only 20% of males had a urine test.

For cervical smears taken within the last three years there were no significant differences in levels of uptake between the social

classes in younger age groups, but in the 46–69 years age group only 40% of social classes 4 and 5 had a smear in the last three years compared with 68% in social classes 1 and 2.

There were highly significant differences in immunization rates — only 58% of children under five years of age in social classes 4 and 5 were completely immunized while the figure for social classes 1 and 2 was 94%.

Surprisingly up to 1984 we had always felt as a team that we gave far more attention to our deprived patients. So what did we do?³⁶ First of all we fortified our opportunistic screening — when the deprived patients attended the surgery, for whatever reason, then we also gave them preventive care and we included the rest of the family if they were there too. The practice nurse fitted in whoever turned up.

We developed the deprived estate household preventive care card which was stapled to the very front of the A4 folder and acted as a prompt for every forgetful, ignorant or idle doctor or nurse. The top section of the card listed the adults in the household and itemized what they should have had done. The lower section listed the children with their immunization needs. A central register was kept and health visitors had a copy of the card when making home visits and they exhorted families to attend. We wrote twice within a year to each household, a kindly letter about the need for preventive care and attached to it a list of their household with the preventive care that was still outstanding, including sometimes a congratulatory note for anyone who was totally up to date. People are bombarded with information and reminders and offers from their banks, their building societies, their supermarkets, their opticians. It is about time they heard from their doctor about their health.

In every preventive care parameter the deprived community now have equal or significantly better figures than their endowed controls. So the 'blitz' on the deprived estate worked. But the sceptics will say our puny efforts at clinical and preventive health care will of course be swamped by the effects of the continuing social conditions. But the social engineers too are attacking the area and smart new houses now replace the old slums and some open green areas are being preserved. This too has been successful.

As a result of this successful pilot scheme we have now stapled household preventive care cards to the front of every record in the practice. But who is doing all the work? The preventive care team consists of the practice nurse who runs all the clinics organized by the records and computer analyst. Supporting these two linchpin members of the team are the unemployed youngsters of Stockton-on-Tees currently attached to our practice, free of charge, a year at a time, via various phoney government schemes before being slung back onto the unemployment heap. They are keen, bright, quick and they work with the records, the word processor, the computer and one of them works as a nurse assistant. We are way over the totally unrealistic reimbursable limits of two staff per doctor — I wonder how the average doctor copes with 1.2 staff per doctor. The College should be campaigning vigorously for a much larger lay infrastructure in every surgery if we are to carry out effective preventive care.

Conclusion

By implementing the changes in modern general practice there is a potential for high quality clinical work and research — there must be if we are to attract and above all keep for a lifetime our brightest graduates in day-to-day service general practice. And if we fulfil that potential then we will have so much to teach our specialist colleagues.

By providing discriminatory clinical and preventive care in a way that only community based teams can do then we can begin

to narrow the health divide that exists today just as it did in Mackenzie's time.

I wonder — and perhaps even hope — whether, if he had been alive today, James Mackenzie might have stayed happily in Burnley general practice.

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