The College in my practice

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THE Royal College General Practitioners has been so much part of my life and means so much to me that it has been difficult to choose a particular theme in answer to the invitation to write something personal, relevant to the College's 40-year history.

Under the title I have chosen, I want to write about the interplay between what went on in my practice and what I experienced in the College. I was involved in both, concurrently, for almost 30 years. It was the interplay in both directions which made the experience so significant. As a counter theme, I want to speculate about why the College evidently does not have the same importance for all general practitioners in the UK as it had for me.

These two themes will mean going back to 1952 when, still a trainee in practice, I became a foundation associate (there cannot by now be many left of the original 142 associates). It will mean saying a little of my time as president, but more about the intervening years. There would be little point, however, if I did not believe that the two themes are still relevant to the present time, 1992.

The starting point

In 1951 I joined, as a trainee, the practice in which I have worked throughout my career. The main site of the practice was in a high street shop, dingy without and within, furnished and equipped almost without change since my senior partner's father had set up there, in poverty, in 1885. The contrast between this and being a medical registrar at the London Hospital, working for deservedly famous chiefs, was striking. Eyebrows had been raised at my choice.

But choice it had been. Fulfilling the role of general practitioner locum, when already started on a psychiatric career, had been a revelation to me. I suddenly found what I had been looking for since switching from Latin and Greek literature to medicine at university under the impact of the second world war. It was the first time that I had felt completely sure that medicine was right for me. I relished being free from supervision and working with people in their own surroundings. The revelation was sudden and late, but it changed my direction for the second time and it lasted throughout my career.

As a trainee I started to attend local medical meetings. They were as depressing as the shop in which I worked. They were dominated by ordinary people whose reactions were predictable. Most of those present seemed to have lost all ambition and no longer valued the work they were doing. Thinking and development were for other people and these others were in the hospital world which I had left. The only role models were specialists and the only new thinking was about how to run small businesses under the new National Health Service. It was a world I had not known before — the one described by Joseph Collings in his scathing review of British general practice.[1]

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It was against this background and against the wider one of despondency about any future for general practice in an increasingly complex medical scene that I attended the first meeting of the north London faculty of the College in 1953. It was like a breath of fresh air. The chairman was Stephen Taylor, then writing his book *Good general practice,*[2] and an enthusiast at all times. His deputy was Lindsey Batten, an excellent clinician and a scholarly man of letters. George Abercrombie was already chairman of the first College council and Oliver Plowright, a man of distinguished appearance, was my family doctor. All these men and others present seemed to take pride in their work, to believe in the future, to have new ideas and to be able to express them well. So the new College opened a window in a musty old room. Through this I had a glimpse of how things could change in the practice I had joined and, more widely, in our then neglected branch of medicine. In retrospect, the challenge was daunting and most of the medical profession expected little from what we imagined.

1953–79

The interplay between practice and College was, most simply, between what one was doing oneself and the discovery, through the College, of what others facing similar problems were doing. For example, in 1954 the practice shop needed conversion into purpose-built premises with new equipment. The College provided ways of finding out how others were doing this in the best way. But the interplay was also of a more fundamental nature. Practice seemed to consist of a wide range of discrete problems to be solved and unique people to understand. Neither could be linked or held together satisfactorily within such frameworks as undergraduate learning or hospital experience could provide. The College gradually provided suitable frameworks.

Both my concern for the psychological aspects of medicine and an interest in the past which stemmed from my previous education found application in the tasks I was asked to undertake in the College headquarters around 1954. One was to initiate a collection of archives, from which the College library developed, with the help of Michael Linnett. Another was to join the College's first working group about a particular aspect of practice, psychological medicine.[3] The group consisted of Sydney Abrahams, Annis Gillie, John Hunt, Richard Scott, Arthur Watts and myself. I had already been in the first of Michael Balint's groups at the Tavistock Clinic and leaned towards the psychoanalytical end of psychiatry. Arthur Watts' studies of depression in his practice introduced me to a different approach which prepared the ground for the future use by general practitioners of such drugs as imipramine.[4] This working group influenced my own behaviour in the practice, but it was also the first time that Balint's ideas were tried out in a college which remained mainly hostile to them until the publication of *The future general practitioner. Learning and teaching.*[5]

Like Balint seminars, this working group examined the actual clinical situations which general practitioners faced in part of their work. However, the approach was different — more theoretical, more concerned with classification of symptoms and illnesses, less concerned with the doctor–patient relationship. This epidemiological approach was also the main focus of the College's research committee — my other early involvement under Robin Pinsent, Donald Crombie and Ian Watson. The interplay here was with a study which I had just carried out with my wife about the balance between self care, general practice

care and hospital care.[6] But there was also John Fry's work on continuous record keeping for research purposes, which seemed to link with my own experience of continuing relationships with patients.[7] This record keeping gave opportunities to study the link between one episode of an illness and another, between one illness and another in the same patient, and between the illnesses which occurred in different members of one family.

The same interplay between practice on the one hand and reflection and research with College contacts on the other, enriched my early experiences of trying to teach students and trainees, which had started in 1954 and had been inspired by Henry Cohen's reports on medical education for the British Medical Association.[8,9] Here I think of the first working party on vocational training,[10] of which Bill Hylton was chairman and I was secretary — this group's reports are known to have had an important influence on the Royal Commission on Medical Education in 1968;[11] I think next of Patrick Byrne and the four other co-authors of *The future general practitioner;* then of the members of the first Leeuwenhorst group who came from 11 European countries, from whom I learned much, especially from friendship with Jan van Es (the Netherlands) and Zelko Jaksic (Yugoslavia). The challenge in all these contexts was to find, in the wide range and diversity of what goes on in a general practitioner's consulting room, the essential features which distinguish this role from that of any specialist. Thoughtful people in teaching hospitals, here or in Europe, would say: 'What can you teach that I and my colleagues do not teach already? Well, I suppose you do have the minor illnesses which we do not see'. The need to agree a definition of general practice and to see the essential ways in which it differed and could be accepted as a distinct discipline by universities was an extreme example of the search for linkages, principles and frameworks which I myself needed, even in my practice. Moreover, it compensated for the feeling that I had come down in the world in leaving the hospital. I was not prepared to be seen as second class citizen in medicine. Obsessed by the challenge of specialization, I became increasingly aware of what it was unable to supply. The personal doctor can offer care which is accessible, of broad range, relatively continuous and, above all, integrative. No one of these characteristics is as easily provided by any specialist; in combination they can only be provided by a generalist. This forms a distinctive role which people value as a basis to which specialist care can be added when necessary. In this way, specialists and generalists can relate to each other not as two people who are doing the same job, one better than the other, but as two people doing complementary jobs of equal status within the profession and society more widely.

It was the College which brought together the people determined to think these things out for themselves in a way which nowadays offers inspiration to doctors in other countries. The idea that general practice might have no future in a specialized medical world has receded into the past. But this is not to say that general practice is secure from other dangers in the future.

1979–82

The most important individual contributions made by those whom the College has elected as presidents have almost always been made before they have taken up office. I think that this applies to my own term and that something similar could be said of the College itself at the time I was elected. The College's most obvious initial aims had been achieved. These were a special postgraduate preparation for general practice, the acceptance of the subject as part of all medical school curricula, a postgraduate diploma, a rapid development of research and publications, a leading position as career choice for young doctors and a changed image with the rest of the profession. These achievements had to be sustained and improved, but it was above all a question of 'What next?'

There certainly were new developments during my term as president, but they were the initiatives of others, which I could encourage. I think of John Hasler's influence in starting the patient's committee, still a unique feature among royal colleges. Julian Tudor Hart, Denis Pereira Gray and Christopher Donovan, among others, were developing a cluster of initiatives in prevention and health promotion.[12] The quality initiative, with its roots in the College's first article of association, 'to encourage, foster and maintain the highest possible standards...', was beginning to be discussed. A new, more direct approach seemed possible through American work on the assessment of quality. Audit was discussed for the first time with the British Medical Association. I now attach special importance to the report *What sort of doctor?* from a working group chaired by John Lawson and largely written by Jack Norell.[13] Methods of assessing practice performance were based on agreed criteria. This report coincided with a new willingness from practitioners in several parts of the country to invite inspection of very sensitive aspects of their work. This fundamental aspect of interplay between the College and every practitioner in the country now owes much to Donald Irvine, whose concern with it must have started before 1970.

These and other developments contributed to a very special three years in my own life and that of my wife, during which I enjoyed a wonderful partnership with Alastair Donald as chairman of council. But the interplay between the College and my own practice ended with an acute episode of illness which made me decide to retire from clinical work and to give all my time to the remaining half of my presidency.

Whether senior college officers should or should not attempt to continue in practice is arguable. I think most members of the College would say that they should do so lest their feet leave the ground. But I doubt if I am the only contributor to this series in the *Journal* who will have found the combination exacting and unsatisfactory at both ends (my generous partners likewise). Having now been out of clinical work for 10 years, I have no hesitation in saying that for at least three years one's understanding of the stresses and techniques of practice is still very much alive.

The counter theme

I have been describing the most important among the many reasons why I have valued the College and feel indebted to it. Many other general practitioners will acknowledge a similar debt, but not all among the 30 000 whose work it has profoundly influenced. The College has always had opponents as well as adherents. The opponents have been relatively few, but they have been vocal and interesting to journalists. The indifferent have been more numerous.

It has always seemed likely to me that an institution whose first article of association is 'to encourage, foster and maintain the highest possible standards...' will stir both love and hate, if it is being effective — sometimes even in its most loyal adherents. Accusations of elitism, interference, and of ivory towers are likely to continue, whether through irritation, envy or as a way of excusing indifference. After all, one of the first things I enjoyed about being a general practitioner was the freedom to practise in my own way; but the College has sometimes shown that it was not the best way.

Every generation of College officers has felt concerned and has struggled with the problem of indifference. I shall never forget a discussion with two young doctors in my own faculty at the start of my presidency: 'We do not know what the College does for us nor what we can do for it.'

The problem is, of course, shared with every other medical organization. There can be no easy or single answer. But I would claim that, in writing about the College in my own practice, I have touched on an obvious but fundamental and lasting theme. The interplay is crucial. General practitioners in the face of constant change need help to reflect about what they are doing in response, and to exchange ideas with others. Each of us has something to contribute. If the College is to plant its smallest roots in every practice as it did in mine, its own members and associates must help it to listen before it talks and to see that its talk is useful. After all, those are the principles which count with students or with patients in the consulting room.

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