The Back Pages

viewpoint

Fifty years on

In November 2001, the College of General Practitioners was founded in London, establishing the first academic body for general practitioners in Europe. Golden jubilees are times for celebration and looking back, so better to judge the future. What has the College achieved?

1. **College as a symbol.** The College was founded as a symbol of the aspirations of thousands of GPs. It was a statement that GPs belonged in the family of medicine. The College was a unilateral declaration of professional independence. Fifty years later, the RCGP is the largest of all the 15 Medical Royal Colleges with great influence.
2. **University role.** General practice had been excluded from the universities. The new College surveyed the amount of training in general practice available to medical students and then campaigned for entry of GPs to the universities. Fifty years later, there are departments of primary care in every medical school and medical students are increasingly being taught in primary care by primary care colleagues. In 1952, there was not a single general practitioner professor in the world. Within 11 years of the College forming, the first chair was established in Edinburgh. The relatively small Council of the College provided the world s first professor and then the first professor of general practice in Canada, England, Ireland, and the first professor in a postgraduate university department general practice as well.
3. **Vocational training.** In 1952, there was no training for general practice. Doctors could go into practice without even doing a pre-registration year. Now there is a mandatory pre-registration year and three years of postgraduate training for everyone, and the first GPs are doing 18 months in general practice.
4. **Examinations in general practice.** There was nothing in 1952 and now there is the MRCGP by examination, with the number of candidates approaching 2000 in some years.
5. **Research.** In 1952, general practitioner research consisted of a few brilliant individuals, such as Mackenzie and Pickles. We now have many more internationally known GP researchers. In addition, to the university departments, there are now NHS primary care research networks and NHS research general practices. The College funded the initial models for both in the early 1990s.
6. **Research publications.** In 1952, any general practice research had to be published in a general journal or a journal specialising in some other field. General practice research publications were fragmented. In 1961, the College *Journal* became the first primary care journal in the world to be included in Index Medicus and for the next 40 years led the primary care world in terms of impact factors. The RCGP Occasional Papers have entered the international literature and no other College has yet developed their equivalent.
7. **Assessment in the practice.** Fellowship of the College by Assessment, introduced in 1989, was the first College-run, on-site, practice-based assessment leading to a major professional award in the world. Based on published standards, judged by external peers and patient representatives, annually reviewed, and open to GPs as young as 33 and passed by a GP aged 65. FbA has led on to Membership by Assessment of performance, accredited professional development, and an acceptable system for revalidation by GPs.
8. **International role.** In 1952, GPs were internationally isolated. The RCGP first formed an international committee within its then Communications Division in 1982. It now plays an active part internationally, offers an MRCGP international, and holds the European WONCA Presidency.
9. **Leadership of the medical profession.** In 1952, the leadership of the medical profession was, had always been, and was expected to remain entirely in specialist hands. Now, the President of the GMC, the Chairman of the Academy of Medical Royal Colleges, the Chairman of the Council of the BMA, the Chairman of the Medical Postgraduate Deans, the Director of the London School of Tropical Medicine and Hygiene, and the Chief Medical Officer in Scotland are all general practitioners.

The College has much to be proud of in its first 50 years, but will undoubtedly face great challenges in the next 50.

Denis Pereira Gray

References

1. Fry J, Lord Hunt of Fawley, Pinsent RJFH. *A History of the Royal College of General Practitioners: The First 25 Years*. Lancaster: MTP, 1983.
2. Pereira Gray DJ. *Forty Years On. The Story of the First Forty Years of the Royal College of General*

rcgp 50

"Few skilled craftsmen, be they plumbers, butchers or motor mechanics, would be prepared to work under such conditions or with equipment so bad ..."

Irvine Loudon, quoting, Collings, General Practice in 1952, page 1030

"Milburn's constituency of Darlington has seen a 6% relative increase in premature mortality rates since 1997 ..."

George Davey Smith, reporting, General Practice in 2002, page 1032

"Living with vertical growth rates is impossible, inhuman. But some argue that such unsustainability prefigures not collapse but some post-human future, a profound rupture, a Singularity."

Paul Hodgkin, speculating, General Practice in 2052, page 1034

"I'm worth what I'm worth, but this isn't the life I deserve."

Miguel Torga, 1935, translation **Iain Bamforth**,

contents

Barefoot and empty brain?
What are we to make of journalistic 'alternative' nonsense?

THERE is nothing quite like a good old dreary autumn Sunday: tea in bed, long (usually wet) walks with the dog, a bottle of wine with lunch and plenty of relaxation. Yet sometimes I feel that a whole day without stress is more than I can bear. Then I buy a Sunday paper and read one of the regular features on alternative medicine, such as the Barefoot Doctor (*The Observer* on Sunday), or What's The Alternative? (*The Sunday Times*). These columns release large amounts of adrenaline into my body almost instantly. When I first encountered them, I thought they were what Germans might call typical English humour — hidden, dry, and black, but intensely funny. Honestly, it took me several weeks to realise that they are not examples of English humour at all but examples of British journalism and I am so relieved that Neville Goodman agrees with this point of view.[1]

If this sounds harsh, consider the following small study that was prompted by my encounter with this genre.[2] We determined the frequency and tone of reporting on all types of medical topics in daily newspapers in Germany and the United Kingdom. The following eight newspapers were scanned for medical articles on eight randomly chosen working days in the summer of 1999: *The Times*, *The Independent*, *The Daily Telegraph* and *The Guardian* in the UK, and *Frankfurter Allegemeine Zeitung*, *Süddeutsche Zeitung*, *Frankfurter Rundschau* and *Die Welt* in Germany. A total of 256 newspaper articles were thus evaluated. Eighty articles originated from the German newspapers and 176 from the British; thus British newspapers reported on medical topics more than twice as often as German broadsheets. Articles in German papers were on average considerably longer and took a positive attitude more often than British ones. As for articles specifically dealing with complementary medicine (for obvious reasons, I prefer the term complementary medicine — whatever alternative medicine is, it is no alternative!), there was a big surprise: in the UK the tone of these articles was unanimously positive (100%) whereas most (75%) of the German articles on complementary medicine were critical. One might conclude that UK journalists abandon their critical faculties when writing about issues related to complementary medicine. The Barefoot Doctor may thus be the rule rather than the exception.

Hang on a minute, you might say, times are difficult enough and we don't need anyone making semi-nationalist attacks on British journalism. This is not my intention. On the contrary, I believe that, on average, British journalism is better than that of any country I have spent enough time in to judge (Germany, Austria, United States and France). However, I do feel that there is one remarkable exception to this high standard: British journalists waffle on complementary medicine.

Goodman rightly complains about the fact that The Barefoot Doctor wants us to believe that bed-wetting is caused by a deficiency of kidney energy.[1] Susan Clark, in her column What's The Alternative?, regularly goes much further; some of her advice could even endanger the health of the nation. For example, Ms Clark recently recommended a herbal remedy for children to help them relax, which has been repeatedly associated with hepatotoxicity.[3] This prompted me (for the first and probably last time) to write a letter to the editor of a newspaper. It concluded by asking, What is the alternative to Ms Clark's column? I believe reliable information would be a good start! I had much the same response as Dr Goodman: the letter was neither acknowledged nor published.

What are we to make of this type of journalism? One reaction (my initial one) is to regard it as a hoax. If it amuses people, why not? After all, journalists have to earn a living too. However, if this type of journalism hinders adequate and appropriate health care or endangers people's health, we might need to think again. Smiling condescendingly or totally ignoring this current journalistic fad of promoting alternative nonsense seems an inadequate, almost irresponsible response by doctors and other health care professionals.

Goodman takes a different approach and powerfully argues that, because such nonsense is at the core of alternative medicine, we should dismiss the idea of adopting it into mainstream health care. The integration of nonsense, he would argue, would probably result in nonsense, and it is well worth listening with scepticism to those who want integrative medicine as *l'art pour l'art*, irrespective of any accepted criteria, such as efficacy and safety.

Here I disagree with Goodman, not totally but in parts. I think that Goodman's condemnation is too sweeping. It is one thing to condemn bad journalism or bad

References
1. Goodman NW. The Observer's Barefoot Doctor: explanations for the credulous. *Br J Gen Pract* 2001; **51:** 952-953.
2. Ernst E, Weihmayr T. UK and German media differ over complementary medicine. *BMJ* 2000; **321:** 707.
3. Clark S. What's the alternative? *The Sunday Times*. [*Style* magazine.] 2001; 22 April: 43.
4. Ernst E, Pittler MH, Stevinson C, *et al*. *The desktop guide to complementary and alternative medicine*. Edinburgh: Mosby, 2001.
5. Ernst E. Only 0.08% of funding for research in NHS goes to complementary medicine. *BMJ* 1996; **313:** 882.
6. Ernst E, Wider B. UK medical charities and clinical trials. *Br J Gen Pract* 1999; **49:** 755.
7. Ernst E, White AR. The BBC survey of complementary medicine use in the UK. *Complement Ther Med* 2000; **8:** 32-36.
8. FACT Website:

medicine. It is quite another to equate everything that exists under the broad umbrella of complementary medicine with bad, unproven or implausible medicine. Some forms of complementary medicine are well documented in terms of efficacy, safety, and even mechanism of action. With others, a large degree of uncertainty remains. And others again not only fly in the face of science but have been shown to do more harm than good.[4]

There is currently a fair amount of reasonably rigorous research into this area. My department, for instance, has produced more than 60 systematic reviews relating to complementary medicine (a full list is available from the author free of charge). We have also just published a book which provides a brief and strictly evidence-based summary of the state of the art.[4] But the field of complementary medicine is huge and progress is slow. We are still the only University Department of Complementary Medicine in the UK and obtaining research funding is depressingly difficult. Only 0.08% of the NHS Research and Development budget goes into complementary medicine research.[5] For UK medical charities, the equivalent average percentage is even lower at 0.05%.[6] This hardly measures up to the fact that about 20% of the UK general population use at least one type of complementary medicine in any given year.[7]

So what should be done? Obviously journalists need eye-catching material but readers have a right to accurate information. Therefore I suggest that journalists do what they are (or should be) trained to do: report on the facts as they emerge. More than 1000 research papers on matters relating to complementary medicine are now being published every year, and most are conveniently summarised in our review journal, *Focus on Alternative and Complementary Therapies*.[8] This should provide more than enough material for newspaper columns. All a journalist needs to do is visit a library to read and understand the research. Once journalists write about the (often fascinating) results of such research work, the public would get a taste for and appreciation of the scientific approach to complementary medicine. Once this ball has started to roll, it might even help create the funds that are so badly needed to study this subject sensitively, yet rigorously.

Edzard Ernst

rcgp 50 - the highlight of 2002...

In 2002, from the evening of Sunday 9 June to the afternoon of Thursday 13 June, the RCGP will celebrate its 50th birthday by throwing a tremendous party for at least 2500 people. Every general practitioner in Europe is invited; and every member of their families; and every member of an academic department of general practice or a primary care team; and every medical student. The party is the 2002 WONCA Europe Conference (**www.woncaeurope2002.com**). It will be held right in the centre of London at the Queen Elizabeth II Conference Centre opposite Westminster Abbey with views across Parliament Square to Big Ben and the London Eye. The tone of celebration will have been set the week before when the UK has a four-day holiday weekend to celebrate the Queen s Golden Jubilee. Conference social events will take us onto the river Thames, to Madame Tussaud s, and to the British Museum.

There will be a huge and varied academic programme. We have received hundreds of abstracts from countries right across Europe and beyond. There will be an immense choice of free-standing papers and posters, running side by side with an exciting array of workshops and symposia. A clinical skills strand will provide postgraduate education which is firmly grounded in the reality of practice. Seven very broad themes will ensure that all interests and enthusiasms can be accommodated.

One of the key intentions of the organisers is to expose delegates to ideas and thinkers from outside medicine, and two of the four plenary keynote speakers will start this process. On the first day, Martyn Evans, the philosopher from Swansea who co-edits the journal *Medical Humanities*, will develop the thinking that informed his 1998 RCGP Occasional Paper, *The Human Side of Medicine*. On the final day, John Adams, Professor of Geography at University College London, will discuss risk, freedom, and responsibility in the context of the dialogue between patient and doctor. In between, Carl Edvard Rudebeck, a general practitioner from Sweden, will explore the place of empathy and imagination within the consultation, and Professor Carol Herbert, leading Canadian family practice researcher and Dean of the Faculty of Medicine at the University of Western Ontario, will examine future priorities for primary care research.

Perhaps the most interactive sessions will be presented by Progress Theatre. Actors, working with a group of patients or health professionals in training, have developed short pieces of theatre, about 20 minutes long, which are based on the difficulties that the patients or students have experienced. Each show consists of two performances of the same piece. The first time it is run as originally developed so that the audience can understand the issues and story. The second time round, members of the audience are encouraged to make suggestions about how things could be different but with the proviso that only the actions of the central protagonist, who is a health professional or one in training, can be changed. The audience is inevitably drawn in and always makes multiple suggestions about how the situation could be improved. Sometimes individuals from the audience choose to act part of the central role themselves, more commonly the theatre group incorporates suggestions from the audience and improvises how this affects the other protagonists. Since only the protagonist s actions can be changed, the process avoids wish lists (I need more time/a different boss) and focuses on what we ourselves can do to improve any given situation.

To mark the College s 50th anniversary, we have invited Marshall Marinker to organise a symposium entitled A College of Ideas , which will review the ideas that have defined the College and recognise the contributions of some of those who created and promulgated these ideas. The aim is in equal part celebration and critical reflection. Major figures who have agreed to contribute include John Howie, Julian Tudor Hart, and John Horder.

Inevitably, a brilliant party in the heart of London is expensive and the registration fee for the Conference is not a snip, but this is not an event to be missed. Previous WONCA Europe conferences in, for example, Stockholm, Prague, Vienna, and Tampere have shown how easily friendships between GPs and primary care researchers across Europe can be seeded and nurtured. The intensely common ground in the experience of the general practice consultation shows us again and again how much we share and how much we have to offer each other. So start to save, beg, borrow or steal, whatever it takes but be there!

Iona Heath
Chair, WONCA Europe 2002 Programme Committee

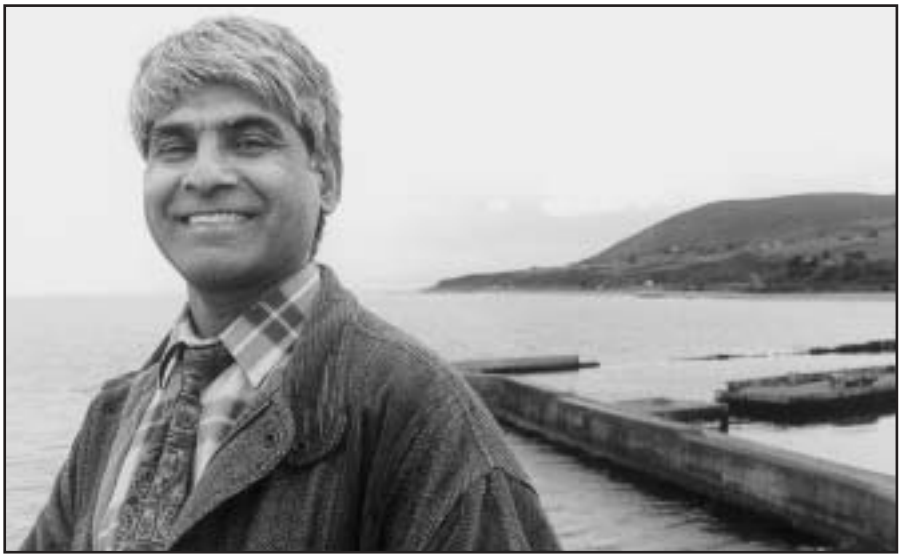
Single-Handed
General Practitioners in Remote and Rural Areas

Susan Bowie Hillswick, Shetland

Single-Handed — General Practitioners in Remote and Rural Areas, by Rosie Donovan and John Bain (Whittles, Caithness 2001, 1 87032509 5) may be ordered from Scottish Book Source, 137 Dundee Street, Edinburgh, EH11 1BG, tel: 0131 229 6800; fax: 0131 229 9070 or e-mail: **orders@scottishbooksource.com** at £15 plus postage (10% UK and 15% airmail).

All other enquiries to Whittles Publishing, tel: 01593 741240; fax: 01593 741360 or e-mail: **whittl@globalnet.co.uk**

John Smith was born on Lewis and has lived and worked there all his life. After 20 years in Stornoway, he moved, in 1991, to the village of Carloway, on the Atlantic side of the island. He works single-handed but has some help with holidays and night cover via the Associate Practitioners Scheme. He has a registrar, and is an RCGP examiner. He has around 1300 patients. Three quarters of his consultations are conducted in Gaelic. He is a keen piper, and is involved in the local piping society and chairs a local arts organisation. He has a boat, and 'does a lot of fishing'.



Devendra Singh Helmsdale, Sutherland

For those of us lucky enough to visit Crieff for last year s memorable Spring Meeting, one of the highlights was a magnificent exhibition of images by the Scottish-born, Canadian photgrapher, Rosie Donovan. Her photographs have now been published in book form: *Single-Handed — General Practitioners in Remote and Rural Areas.*

It is a pleasure to see them for a second time. The subjects are Scotland s isolated single-handed general practitioners, from the islands of the west and north, and remote corners of the mainland. Each doctor is pictured out of doors, where they work, literally part of their landscape.

Rosie Donovan didn t just take her subjects pictures she interviewed them about their lives, their work, and their communities. The transcripts of her conversations, edited by John Bain, professor of general practice at Dundee, are published opposite the photographs.

Words and images together paint a portrait of an extraordinary group of doctors who work, sometimes for decades, in environments beautiful but harsh. Most of us would be running for cover after the first fortnight on call.

Alec Logan

References
1. Collings JS. General Practice in England today. A reconnaissance. *Lancet* 1950; **i:** 555-585. At the time he wrote this report Joseph Collings, previously a general practitioner in Melbourne, Australia, was Research Fellow at the Harvard School of Public Health in Boston, Massachusetts.
2. ibid. p.583.
3. ibid. p.580.
4. ibid. p.578
5. Webster C. *The Health Services since the War.* Volume. 1: *Problems of Health Care. The National Health Service before 1957*. London: HMSO, 1988: 356.
6. Loudon I, Horder J, Webster C (eds). *General Practice under the National Health Service, 1948-1997*. Oxford: Clarendon Press, 1998.
7. The GMSC was a very unusual body. It was both a statutory committee, elected by the Local Medical Committees of general practitioners set up in 1913 by the National Health Insurance Act, and a sub-committee of the British Medical Association which of course was, and is, a non-governmental association. Successive ministers of health regarded the GMSC as a very powerful body because it was representative of all general practitioners, whether or not they were members of the British Medical Association.
8. See Morrell D, Introduction and overview ; Bosanquet N, Salisbury C, The practice ; and Horder J, Conclusion , in Loudon I, Horder J, Webster C (eds). *General Practice under the National Health Service, 1948-1997*. Oxford: Clarendon Press, 1998.

THE year 1952 was the seventh since the end of World War II, the fourth of the NHS, the second since the Collings Report (of which more later), and it was the year in which the College of General Practitioners was founded. My own career in general practice started in 1952, and ended in 1981 when I changed to a career as a medical historian.

In 1952, the status of general practice within the profession was extremely low. Joseph Collings (1918 1971), an Australian doctor, carried out a survey of general practice in Britain in the late 1940s. His report, which was published in the *Lancet* in 1950,[1] was devastating.

Describing numerous dingy, dirty, ill-equipped surgeries, he remarked that:

> *'Few skilled craftsmen, be they plumbers, butchers or motor mechanics, would be prepared to work under such conditions or with equipment so bad ...'*

At one industrial practice of four partners, two assistants, and a list of 20 000 patients:

> *'The surgery consisted of a small dilapidated waiting room, three equally small and untidy consulting rooms, and a kind of cupboard which served as a dispensary ... The consulting rooms were dirty and ill-equipped. There were no examination couches ... apart from a few rusty and dusty antique instruments, there was no sign of any sort of equipment. I made my visit during an afternoon consulting hour and found a queue of people extending about 200 yards up the street, waiting their turn to see the doctors ... I was told, not without pride, that "We have seen 500 already today"; and I have no reason to doubt it. 'Notes'* [sickness certificates] *and 'bottles' were asked for by almost everyone seen and were supplied on request ...'*[2]

Collings was accused by some of sensationalism by selecting the worst practices and ignoring the good. Although he saw some practices where the standards were beyond reproach, and thought Scottish general practitioners (some were as fine men as I have met anywhere) were on the whole better than the English; the standard of practice as a whole was deplorable.[3]

Although it is difficult to judge a branch of a profession whose members were so intensely variable, in retrospect one is forced to agree with Collings conclusion that the overall state of general practice is bad and still deteriorating. It was a stagnant branch of medicine in which the NHS did

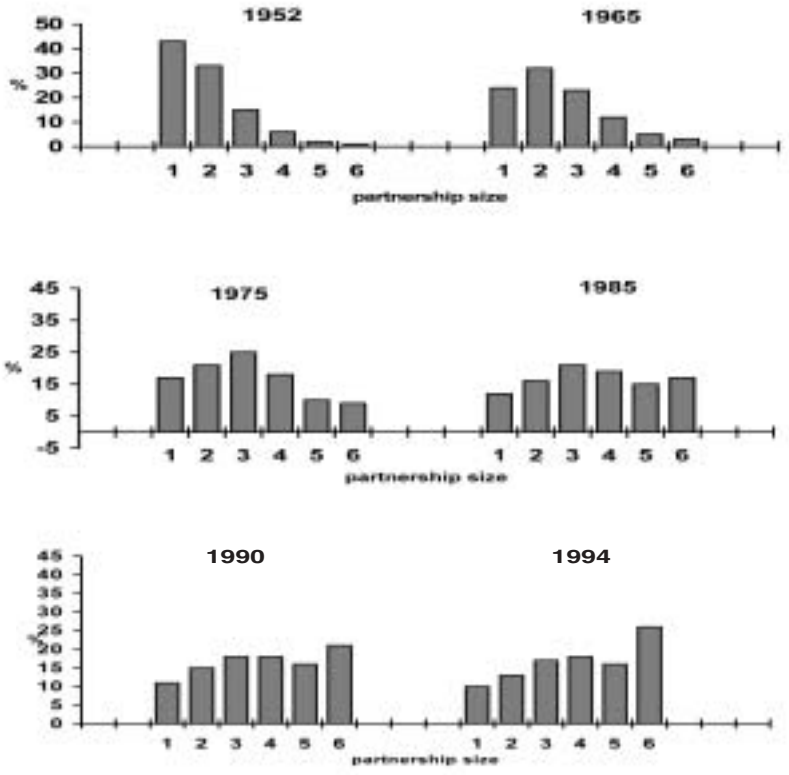


Figure 1. Percentage distribution of unrestricted general practitioners by type of practice, with 1 indicating single-handed practice, and 2 and above indicating partnerships of increasing size up to six or more partners. Source: Health and Personal Social Services Statistics. OHE Compendium of Statistics, 1995, Table 4.16

nothing to disturb the structure of general practice or reward those who tried to produce work of a high standard while increasing the load on the GP to the point of near-breakdown .[4] As Webster has said: most of his [Collings] shots hit the mark with explosive impact ... and [the Report] was the single most effective factor in mobilising opinion in favour of constructive change. [5]

One of the most damaging aspects of British medicine was the frequent denigration of general practice by teaching hospital staff, causing many of the older general practitioners in 1952 to feel divorced from any aspect of medicine which could be labelled as academic, intellectual or even scientific . To retain at least a glimmer of self-respect, established GPs almost invariably prided themselves on being good family doctors. They might not be clever but at least they knew their flock. They felt they were trusted even loved by their patients, and in many cases they were right. To them, the scientific attitudes associated with hospitals and the (for want of a better word) humanistic values encapsulated in the concept of the personal or family doctor, were perceived as incompatible. Belief in this damaging and totally false antithesis was widespread.

In 1952, a majority of practices were single-handed and partnerships tended to be small (Figure 1). Cut off from medical colleagues, most general practitioners practised from their homes, or even converted shops. Some practices had branch surgeries in villages where two, or even one small room served as waiting and examination room. The pre-NHS vision of well-equipped health centres had come to nothing.

Working with large lists (Table 1) under such conditions made it difficult to practice medicine of an acceptable standard. In 1952 it was common for general practitioners to undertake 20 home visits a day as well as seeing 40 50 patients in the surgery sessions. Appointment systems were unknown. Crowded waiting rooms were the rule, sometimes with queues stretching into the street. Co-operation of general practitioners with the nursing services employed by local health authorities was minimal. The only clinical record in general practice was a hopelessly inadequate medical record envelope.

In 1952, with the exception of chest X-rays, direct access to hospital laboratories or radiology was denied to most general practitioners. There was virtually no formal postgraduate education in general practice, and very little research.[6] A large part of treatment consisted of bottles of medicine, most of which were useless but few actively harmful. By today s standards there were few effective drugs. There were, of course, no disposable syringes and gloves. The sterilisation of glass and metal syringes was tedious, and the breakage rate high. Knowledge of psychiatry was often so abysmal that phenobarbitone was prescribed liberally for patients with a real or suspected psychiatric or functional disorder.

Table 1. UK. Number of registered resident population ('list size') per unrestricted general practitioner, 1951–1995. Source: OHE Compendium of Statistics, 1995. Table 4.11. *Estimate.

Year	Number of population per general practitioner
1951	2492
1956	2282
1961	2239
1966	2360
1971	2330
1976	2215
1981	2050
1986	1881
1991	1812
1993	1799
1995*	1782

It has been said that the greatest achievement of the NHS was that it brought high quality specialist care to the whole of the country. Thus, by 1952 the hospital service was forging ahead in a state of high morale associated with the early days of what has become known as the therapeutic revolution a revolution not only in pharmacology and diagnostic procedures, but also in surgery and anaesthetics. These advances hardly touched general practice, where low morale and stagnation stood in stark contrast with the hospitals. Why was there such a difference?

When the NHS was introduced, general practice had evolved from a long established, but often forgotten, state medical service National Health Insurance, introduced after the Act of 1911 and colloquially known as the panel . This service provided free general practitioner care (but not hospital care) for workers below a certain level of income. By the 1940s, more than half the population were panel patients , but the greatest weakness of this service was that it did not cover dependents. It is only a slight over-simplification to say that general practice under the NHS was simply an extension of the National Health Insurance system to the whole of the population. The opportunity for radical change was rejected by general practitioners who insisted on remaining independent contractors, paid by capitation fees. Any other system (such as a salaried service) would, they believed, involve loss of freedom. The opportunity provided by the NHS for radical reform of general practice was lost. There was no leadership apart from the GMSC (General Medical Services Committee of the British Medical Association) which spent its time arguing about pay and terms of service, showing little if any concern for standards or education.[7]

In spite of all this, competition to enter general practice was intense in the late 1940s and early 1950s. In part this was owing to the demobilisation after the war of doctors who served as medical officers in the armed forces, and ex-servicemen who chose medicine as a career and were funded by generous post-war grants. Not only was there a post-war surge in numbers, but the cohorts of medical students were older than usual and many of us were married with children. Looking back, it would be easy to assume that the brightest students chose a career in hospital medicine, leaving the dullards with the alternative of general practice. Such an assumption would be quite wrong. Of my contemporaries at medical school, many of whom were very bright indeed, all except one put general practice as their first choice Although I can only write about the small group of my contemporaries, after years of being under orders of one sort or another, what we wanted most of all was independence and responsibility. We wanted to run our own show .

By the 1970s, enormous improvements had occurred in standards and organisation of general practice, and in practice premises and equipment. The factors which caused this transformation were many, and far too complex to discuss in an essay of this length. Very little of the transformation, however, came from central government (The Ministry of Health) or from the General Medical Services Committee which saw its role as political (pay and conditions of service) rather than educational. But a major factor was the work of the College (later The Royal College) of General Practitioners.[8]

For any doctor who was in general practice in 1952, the extent to which the discipline has changed is nothing short of astonishing, as one can see by contrasting what I have described with what Kurt Stange describes in his editorial (page 963). I believe that the transform-ation of general practice over the past 50 or so years is the most profound transformation of any branch of medicine in the NHS.

Irvine Loudon

General Practice, Health, and Health Care 1952, 2002,

1952

LOOKING back over the previous 50 years from a mid-20th century vantage point, the Chief Medical Statistician, Percy Stocks, saw a period of tremendous progress, with infant and child mortality rates having fallen to around a one-fifth of the level in 1900. Recent progress had been less encouraging death rates in middle age, especially among men, with the male excess in risk of dying between the ages of 55 64 years increasing from less than a quarter, to more than three-quarters from 1900 to 1950. The rising problems were lung cancer, coronary heart disease (CHD) and peptic ulcer, which were threatening to counterbalance continuing falls in deaths from infectious diseases. Epidemiology was rapidly changing from a communicable disease discipline to one almost exclusively concerned with non-communicable diseases.

Socioeconomic inequalities in health were little discussed, and the 1951 Decennial Supplement which provided the first social class data since 1931 suggested that inequalities in premature mortality rates were at an all-time low, and in any case the National Health Service was thought to be the solution to any inequalities that remained.

The NHS, only a few years old, remained a contentious political issue. GPs had voted 2 to 1 against participation in the NHS in December 1946, and applauded when Nye Bevan the architect of the NHS was compared to Adolf Hitler by the BMA, whose leadership had strong Conservative Party links. But with pay guarantees, and the promise that salaried general practice service would not be introduced, a large majority of GPs finally agreed to work within the NHS. The first successful attack on the principles of Bevan s NHS came, instead, from within the Labour party, when the Chancellor, Hugh Gaitskell, introduced charges for dental and optical services; Bevan resigned as a cabinet minister. The Prime Minister, Clement Attlee, claimed that there was no retreat from the principles of the NHS, that charges would increase efficiency and reduce waste in the system, and would be temporary. By 1952, the newly elected Conservative government appeared to have policies little different from their Labour predecessor.

A host of (now embarrassing) projections about health and health care in the year 2000 were published by those safe in the knowledge that they wouldn t be alive to find them wrong.

2002

AT the beginning of the 21st century life expectancy is over 75 for men and over 80 for women increases of around 12 years for men and 10 years for women from mid-century. Improvements are now being driven by falling mortality rates in middle-aged and older adults, rather than among infants and children. Treatments for some of the major killers breast cancer and CHD are now available, and fewer older adults smoke. The declines in death rates from chronic diseases are spectacular; for example, a 17% decline in male CHD and 18% decline in female CHD deaths in just six years from 1994 to 1999. Trends for less common causes accidents and violence (and suicide in younger adults in particular) are less favourable, and morbidity measures suggest that the increasing proportion of people staying alive do not feel healthier. Infectious diseases have failed to disappear (TB, HIV/AIDS, chlamydia, other STDs, hepatitis C), and diseases long thought to be non-communicable (peptic ulcer, cervical and stomach cancers) may have an infectious origin.

Inequalities in health have been a political football since the Black Report of 1980, and under the Thatcher and Major regimes discussion of inequalities was virtually banned. Disparities between social groups are larger at the end of the century than at any time since comparable records began. The New Labour health minister, Alan Milburn, declared an ambition not only to improve the health of the nation but to improve the health of the worst off at a faster rate . Early indications are not good. The poorest constituencies in Britain show a worsening in mortality rates since Labour returned to office. Milburn s constituency of Darlington has seen a 6% relative increase in premature mortality rates since 1997.

The NHS also appears to be in perpetual crisis. Far from being temporary, user charges introduced in 1951 have expanded greatly. Privatisation of health care has been rebranded as Private Finance Initiative (PFI), or Perfidious Financial Idiocy according to the editor of the *BMJ*. Mortgaging the future for temporary gain, but a *shibboleth* for New Labour. No dissent is tolerated. The Prime Minister, Tony Blair, claims that there is no retreat from the principles of the NHS and that charges merely increase efficiency and reduce waste in the system.

Projections about health and health care in 2050 are published by those safe in the knowledge that they won t be alive to find them wrong.

2052

Scenario one

LIFE expectancies continue to grow, and in 2052 men live to 80 and women to 85. There is less focus on mortality rates and more on reliable sources of morbidity data which show that people live longer with chronic conditions and limitations to activities of daily life; furthermore, increasing levels of obesity constrain the range of such activities. Asthma, eczema, and diabetes are common, as are ageing-related problems dementia, macular degeneration, and deafness. Major contributors to adult mortality are non-smoking related cancers (colorectal, prostate, breast, lymphomas, etc), diabetes, suicide, and deaths at such advanced ages that the discredited term of senility makes a comeback. Screening for genetic susceptibility is widely used for detecting those who could benefit from (mainly) pharmacological interventions.

Health inequalities continued to grow. Differential health care access feeds inequalities in health outcomes. The NHS is slowly privatised as PFI lease-back charges and defaulting private sector concerns destabilise coherent public sector funding. In 2024, the last remaining university department of Public Health becomes a department of Health Care Financing. The *BJGP* ceases publication in 2028, superseded by web versions of *Medeconomics* and *Investors Chronicle*.

Projections about health in 2100 are published by those already planning the most fashionable place for a nonagenarian to see in the next century.

Scenario two

THE first case of smallpox occurs in early 2003, from suicide smallpox-carriers operating in major British cities. Efforts to select virulent strains for dissemination are successful. Outbreaks in other parts of the world lead to the most serious recession since the 1930s. Health in Britain resembles that of Eastern Europe in the 1990s, with declines in male life expectancies (owing to increasing mortality in young and middle-aged men) and smaller falls in female life expectancy. STDs, HIV/AIDS and drug-resistant TB rates increase rapidly, and the Government of National Unity Labour, Conservative, and the British National Party abandons welfare medical care. The *BJGP* ceases publication in 2014, superseded by web versions of *Medeconomics* and *Soldier of Fortune*.

Nobody bothers to make any projections regarding health and health care in the year 2100.

George Davey Smith

a taxi driver writes . . .

I HAVE engaged, over the years, in a sort of international health system research based on my continuous poll of taxi drivers. In the United States I always ask taxi drivers whether they have health insurance (none do, except through spousal workplans) and ask their opinions of the quality of health care (too expensive, too unavailable and, when available, too fragmented) as my quasi-scientific approach to the public perception of health systems.

I am sure the government takes years and millions of dollars to find out the same thing. One of my favourite responses was from a taxi driver in Havana who said that their system was great, since he was a taxi driver and yet his son was studying to be a family doctor. A few years ago, I was riding from somewhere to somewhere else in London and asked my usual question of the taxi driver, I m a doctor visiting here. So what do you think of the health care system ? Since the 1970s, every cabbie in London has been generally supportive of the NHS, a fact which I use to confirm that it is working for the most part. This cabbie put it more succinctly than most when, after giving my question a great deal of thought, he said, Well, guv, in my opinion, you could throw the whole lot of it away and give me my GP and it would be just fine .

Whatever else general practice is struggling with in the UK, the cabbies are strongly behind their GPs and that is no small accomplishment. I saw a television drama years ago about cabbies in London called The Knowledge and the statement was made that two things were necessary to be a successful cab driver: an understanding of people, and The Knowledge. Since those are also happen to be the prerequisites for being a good GP, cabbie opinions about quality matter all the more.

John Frey

As Moths to the Flame

Primary care, technology, and the next 50 years

References
1. Orlan, performance artist. Quoted in: Dery M. *Escape Velocity*. London: Hodder & Stoughton, 1996.
2. Dery M. *Escape Velocity*. London: Hodder & Stoughton, 1996.3. Kurzweil R. *The age of spiritual machines*. Penguin, 2000.
4. All figures here from A survey of technology and the poor . *The Economist* 10 November 2001.
5. Dixon A. There s a lot of it about. *Br J Gen Pract* 1986; **36:** 468-471.
6. See, for example, Trilling JS. Selections from current literature, psychoneuroimmunology: validation of the biopsychosocial model. *Fam Pract* 2000; **17:** 90-93.
7. Macinko J, Starfield B. The utility of social capital in research on health determinants. *Millbank Q* 2001; **79(3)**. www.milbank.org
8. Felitti VJ, Anda RF, Nordenberg D, *et al*. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *Am J Prev Medicine* 1998; **14:** 245-258.
9. For more on the Singularity, visit **www.kurweilai.net**. For a sceptical view of techno-hype, see Regis E. *Great Mambo Chicken and the Transhuman Condition*. New York: Viking, 1991.
10. Swimme B. @sheffieldsw-pct.nhs.uk *The hidden heart of the cosmos*. Maryknoll, NY: Orbis Books, 2000.

'I want to fight against the inborn, against DNA. Religion and psychotherapy maintain we must accept ourselves as we are … but in an age of genetic manipulation this is a primitive outlook'.[1]

TECHNOLOGY is accelerating. Look at any field and you find doubling times that astonish. Such growth is best known in computing but exponential growth trends appear everywhere (Figure 1).

Nor is it just technical change trace the amount spent on education or health over the past century and the same soaring spikes appear.

We consistently underestimate the rate of technological change because exponential growth is deceptive. Even the billion-fold increase in computing power encompassed within my professional life has made comparatively little difference to everyday practice.

The old parable of the emperor enthralled by chess illustrates the deceptive power of exponential growth. Enchanted by the game, the emperor allows its inventor, a mathematician, to name his reward. The mathematician requests one grain of rice on the first square of the chess board, two on the second, four on the third and so on. Getting through the first half of the board is childishly easy but by the sixty-fourth square the emperor is long bankrupt. In fact it s not until the thirty-second square that the emperor gets worried. At this point he has to give some four billion grains equivalent to a good-sized field of rice.

The reason that our experience of geometric growth rates has, so far, seemed containable is that we have been covering the first half of the chessboard. Even computing power has only doubled 34 times since the construction of ENIAC in 1946 and just as for the emperor, it is only now that computational life is beginning to get interesting. For other technologies we are still on the early placid plains. Genomic knowledge is currently doubling every 15 months but there have only been around 14 doublings since Watson and Crick. Similarly, Internet nodes may be increasing annually by 30% but we have still have some way to go before the critical thirty-second square.

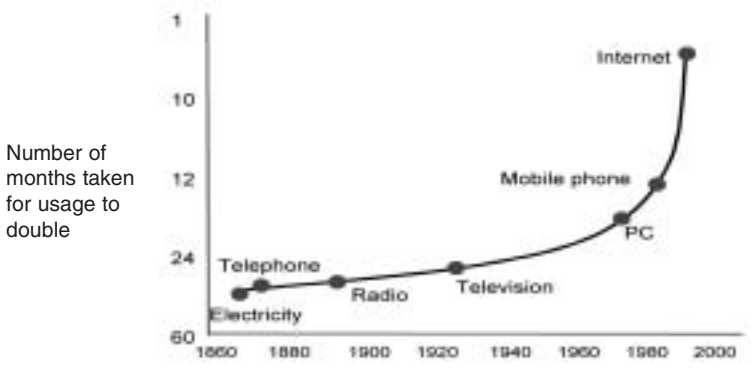


Figure 1. Rate of mass adoption of inventions. Doubling time: 12 months. Adapted from. 'The 21st Century: a Confluence of Accelerating Revolutions' (Keynote Speech, Foresight 8th Technology Conference, November 2000 by Raymond Kurzweil).

Collectively, these trends and the social process that create them constitute the accelerating techno-culture.[2] Culture, science, medicine, and politics will all be dominated and driven by exponential change created by interlocking technologies. This is the central predictability about the future. And, since technologies feed off each other, the emerging technological culture will itself be subject to further, hyper-acceleration. Between now and 2025 we are likely to experience the same amount of technical advance as occurred in the whole of the twentieth century.[3]

So life beyond the thiry-second square, the life we are increasingly embarked upon, will be created and controlled by a group of reinforcing technologies whose antecedents we experience but whose scope is only just beginning to be visible: a therapeutics revolution that inexorably reaches beyond pathology and lifestyle to re-order our sense of what it is to be human. A genomics that unpacks the shimmering mirage of extended life. Virtual realities that seduce the senses and replace relationships. Nano-technologies that thrust manufacturing into a different economic realm.

Of course other futures are equally plausible environmental collapse, vast inequalities, pandemics, oppression, and terror. Huge difficulties still need to be addressed but, in general, technology is part of the solution, not part of the problem. In rural Bangladesh, access to mobile phones has reduced the cost of living by up to 10%. Since 1978 the 40 poorest countries have doubled per capita income and life expectancy.[4] Tackling inequalities should reinforce, not weaken, the techno-culture.

So what can primary care offer a citizenry variously delighted, confused, fragmented, and transformed by these possibilities? Our claim to a future centres on four attributes: scientific, technical, relational, and existential.

The scientific basis for having generalists is that the predictive value of a symptom or test increases with the prevalence of the associated disease. Our diagnostic interpretations are tuned to low prevalence

populations and our hospital colleagues to high prevalence. This is why GPs are relatively poor at making diagnoses but good at diagnosing the (for us) highly prevalent state of normality.[5] Capturing this scientific core of our trade is both possible and essential. It is to our shame that we can not already state the predictive value of the common symptom complexes seen in general practice. We should be able to say to patients You ve had rectal bleeding for three weeks. For someone your age and sex this means you have an X% chance of serious disease. If we are serious about general practice as a discipline, the RCGP (and not BUPA or MSD) should create, guarantee, and profit from such generalist-tuned data.

Technical competence is essential if we are to retain trust. Rapid advances in therapeutics, imaging, and genomics will offer particular challenges for generalists. We will survive if we can offer high quality advice about most aspects of most options. If not then we deserve to go the way of lamp lighters.

Coping with illness and ageing is about relationships sick people want someone to trust and chronic disease demands the long-term integration of multiple interventions. The public will continue to want care delivered through durable, convenient relationships with people whom they trust. But there is also a deeper reason for providing health services through good primary care. Health is intimately tied to social networks and ill people get better quicker when they belong to rich networks of relationships.[6,7] Conversely, fractured families and neighbourhoods cause ill health.[8] Primary care remains part of the dwindling system of community nourishment and we should use this pivotal role to rebuild the social capital that still underpins health.

Finally, primary care will continue its present role of helping people write their biographies as they deal with the consequences of death and disease. This existential role will extend as the accelerating techno-culture destroys age-old certainties and collapses ancient dichotomies (see box).

These categories have formed the skeleton of human thought for millennia. Their collapse is profoundly disturbing. Such existential anxieties will touch all aspects of life but they will be central to primary care because, so often, these new ways to govern the flesh will be negotiated in our consulting rooms.

British general practice grew up sheltered by the NHS. All we have experienced in the 50 years since the College was founded has taken place in the long calm lee of 1948. The next 50 years will be different. None of the four core attributes is unique or guarantees us a future. To justify our existence we need to create the tools of advanced knowledge handling that are becoming commonplace in other disciplines. We must get much better at working with other professions. In the time it takes to say Calman-Hine , hospitals have created true multidisciplinary teams that have revolutionised cancer care. Meanwhile, primary care cannot even get practice nurses and district nurses to work together.

Technology destroys old certainties ...

Different species can not be merged
The human form is immutable
There is no choice over the genetic make-up of your children
You have to live in the real world
The weather is unchanging
Humans are the only intelligence
Humans live for under 100 years

And collapses ancient dichotomies ...

Real–unreal
Alive–dead
Male–female
Machine–human
Human–other species
Mind–body

Bouncing back and forth between the future of humanity and the future of the primary care is uncomfortable. The scales are incommensurate, making one seem hyped, the other unduly mundane. In reality, the reflections of these immense outward changes will increasingly fill our surgeries. There, writ small in the intimate confusions of our consulting rooms, the essence of what it is becoming to be human, will be inscribed on our patient s bodies and lives. Making sense of the profusion of technical choice will be the lesser task. It will be the uncertainties unleashed by the accelerating techno-culture, together with social and cultural anxieties, that dominate both our personal and professional lives.

The story of the emperor and the mathematician ends badly either the emperor loses his kingdom or the mathematician loses his head. A similar fate may await us. But let s be optimistic. Life beyond the thirty-second square will surely be uncomfortable but, barring a catastrophic collapse, it will go on. The random dislocations of terror and wars that ravish the body politic like autoimmune attacks may slow doubling rates but, overall, the techno-culture will probably burn ever brighter.

If so, what then? Can the graphs just keep on climbing skyward? Living with vertical growth rates is impossible, inhuman. But some argue that such unsustainability prefigures, not collapse, but a post-human future, a profound rupture, a Singularity. One day so the argument goes the net may wake up .[9] Or self-designing software will reach the point where no human input is required. The coming Singularity is the cusp of history where everything changes. At the Singularity, machines will have become more intelligent than we are and life will decamp to silicon. Technological change will rupture the fabric of human culture and we will literally be left behind. This Singularity if it ever arrives is akin to a black hole, an event horizon beyond which it is impossible to see perhaps the departure point for our next massive evolution, or the end of humanity.[9]

Making sense of this future demands new stories, new parables for our evolution that incorporate both science and humanity. Look into the night sky, deep into the arching Milky Way, and you are staring into the galactic centre. The photons that trigger your perception set off on their way 30 000 years ago. Their journey has been longer than the whole of human history. Holding this knowledge as we look into the bowl of the night sky changes how we think about science, stars, and ourselves.

The extraordinary unfolding of the life sciences that we are about to witness can deliver other stories to help make sense of our extending capabilities. Each second, the sun turns four million tons of itself into pure light. A tiny fraction of this gets transfigured into children, clouds, and the energy that drives your cyclic AMP as you read this. Within science, within the techno-culture, are new and deeper ways of understanding who we are and what we might become.[10]

However, science alone will not suffice. Humans create meaning through living, by registering possibilities and pain on the body, by the assiduous searchings of the heart. Such meanings are not automatically granted, are not part of our birthright. The coming incandescent technology will illuminate and inscribe all aspects of medicine. Understanding our humanity and that of our patients, in the light of its possibilities is the core task for the next fifty years. *Plus ca change* it has always been so.

Paul Hodgkin

The Writings of John Hunt
Edited by John Horder
Royal College of General Practitioners, 1992
HB, 402pp, 0 85084169 0

WHEN this book was first published in 1992, Roddy Hughes *BJGP* review drew parallels between the 1952 achievements of the John Hunt who climbed Everest, and this John Hunt, whose role in helping found the College is celebrated in this book. Both tackled and overcame massive odds to do what they did, showing courage, persistence, and vision of a high order. Denis Pereira Gray s profile of Hunt (in his masterly review of the people whose ideas and effort had shaped the College s first 40 years) attributed to Hunt the six key qualities of leadership; these included an exceptional capacity to write clearly with accuracy and precision, as well as having a clear mind and an ability to speak well at meetings.

Different people read books with different expectations and purposes, and so take different things from them. I read this book primarily because I was asked to review it, and I wanted in writing this review to try to place this book in the rather longer perspective of Hunt and the RCGP s jubilee.

The body of the text is in four sections. The first is entitled Clinical Topics and includes papers on Raynaud s phenomenon and disease (the subject of Hunt s DM thesis), the treatment of burns, insomnia, the development of a nursing hoist, and the provision of diagnostic centres for the use of local GPs an idea ahead of its time and reflecting the then exclusion of GPs from adequate open access to investigations. The second section, The Early Years of the College , was the one I found the most interesting. The 12 entries in it include the Report of the General Practice Steering Committee which set the agenda for the foundation of the College, and ends with Hunt s memorable 20th anniversary James Mackenzie Lecture, The Foundation of a College , which no-one interested in the evolution of British general practice or indeed in the history of the Institutions of British medicine generally should miss out on. Here indeed is Hughes organised clarity in taut and lucid prose , and the exhibition of Pereira Gray s other leadership characteristics of energy and of personal and professional commitment to a cause. There are seven entries in the third section on The Development of General Practice . Personally I felt a degree of anti-climax reading them, and I will come back to this later. But as an example, while his Albert Wander Lecture on Religion and the Family Doctor was, as John Horder said in his introduction, detached and tolerant , it seemed to miss opportunities to predict the importance of start and end-of-life issues, and the centrality of culture to the meaning of health to those who live in what was, even in 1969, a multi-cultural Britain. Finally, a section entitled Miscellany , includes interesting bits and pieces around Hunt s later role in the House of Lords, covering among other things his help in defining a new role for the GMC, which he perhaps optimistically hoped would provide a sound basis for the regulation of our profession for many years to come .

However, it was John Horder s informative, analytic, and often personally moving introduction which made this book for me. As well as explaining his choice of what to put in and what to leave out, he tells of Hunt s colonial upbringing in a medical household, of his being at public school and perhaps inevitably then on to Oxford and into the London Medical School establishment. Of a promising career in general medicine and neurology, and a never fully explained move to general practice, in the atypical and rather rarified setting of an exclusively private practice in Kensington; and of the devastating effect of the loss of his first son. The personal closeness of John Horder with John Hunt is evident early on, but suffered a setback in the College s early years when Horder, involved sooner than he felt he was ready to be, accepted the role of Medical Secretary and acted as Hunt s assistant. But then, a return of deepening warmth and empathy when Hunt was later progressively unwell and eventually unable to enjoy his final years as he had deserved.

Horder s story and Hunt s writings complement each other. Horder places Hunt at the surgical end of the surgeon psychiatrist continuum. In his writing, Hunt comes across as deeply London Medical School with the personal networks that that implies; for example, repeatedly referring to the three Royal Colleges at a time when there were first two and then three others in Scotland. The man of the hour in the early 1950s (Hughes might even have likened his influence to Churchill s in the war years as well as to that of Hunt of Everest), Hunt seems to have been strangely silent on the crisis leading to the Charter in 1966. He refers nowhere to the ideas of Balint, seems to underplay the need for professional accountability, and missed the need for the College to help address the inadequate support for general practice in the Medical Schools which lead to the temporary distancing of the University Departments and the College around the time of his Presidency.

John Hunt was the last of the College Presidents I never met. I am the better for knowing him now in a way I did not before. His writings were of his time. Other important contributions (like his 13 RCGP Annual Reports) are not captured in this collation. However, I suspect that only his James Mackenzie Lecture will endure as important contemporary reading indeed, it is his only writing quoted in the recent history of *General Practice under the National Health Service, 1948–1997*. But his example lives on as a full embodiment of the kind of leader we depend on today as much as we have ever done before.

John Howie

Reprint available
As part of the 50th anniversary celebrations The Heritage Committee will be reprinting Dr John Horder's introduction to this book — which includes an outline of the papers, biography of John Hunt and his part in the founding of the College. To order a copy please contact Claire Jackson, The Heritage Committee, RCGP 14 Princes Gate, Hyde Park, London SW7 1PU.

The Oxford Illustrated Companion to Medicine (Third edition)
Edited by Stephen Lock, John M Last and George Dunea
Oxford University Press, 2001
HB, 891 pp, £39.40, 0 85200495 8

THE preface to this sumptuous volume describes a companion as a friend, a guide, and a support in everyday life. This book sets out to fulfil this role for the medic and interested layman. It does so with aplomb. It is not a dictionary of terms but a compendium of topics, some of which are clearly the remit of medicine, like coronary thrombosis , and some of which seem tangential, like creativity , which appears on the same page. Topics are grouped alphabetically in the main, so finding what you want is easy. However, the names of some of the great and the good are included as paragraphs on the margins of pages. Such a one is Sir Frederick Treves who appears alongside the entry for the Elephant Man , Joseph Merrick. Treves was the surgeon who befriended Merrick and wrote an account of his life and deformities. This manner of organisation might make the book difficult to use if the editors did not provide us with a number of useful indexes.

First, there is the topic index, which groups some of the entries under headings such as The Arts , Disciplines and Specialisations and Other Systems of Medicine .

This is perhaps the least useful of the four indexes, as I suspect those that use this book will be looking for specific entries rather than browsing under topic headings. More useful for lay and medical readers alike is the list of individual conditions and diseases. This is fascinating for what it includes; for example, Hantaan pulmonary disease, and for what does not appear; for example, no entry for acne vulgaris. However, some of the more obscure entries relate to historical entities of which more later and we can forgive their obscurity on this account.

The people index is most welcome because of the problem mentioned above. It enables the reader to find names when they are not necessarily covered alphabetically in the text. I was pleased to find that our Sir James Mackenzie gets a mention, tucked away in the margin beside William Pickles and alongside the entry for general practice.

Finally, the editors provide us with a general index which covers subjects that do not necessarily appear on the list. I was not sure why the editors has decided to go with American spellings, which are particularly noticeable in the list. Terms such as anemia and hemophilia appear in the place of those more familiar to a UK reader. The reason is probably that, despite being a British publication, the book has only one UK editor, the other two being American and Canadian.

With all this guidance, it is easy and comfortable finding your way around this book. But, what do you find when you reach the entries? Of interest to readers of this journal, of course, will be what is said about general practice. A good summary is given of the development and current stage of general practice from the British NHS perspective. However, I cannot help feeling that almost as this book is published the entry is out of date. Fundholding and the 1990 Contract are covered but there is no mention of Primary Care Trusts or the rise of the salaried service. This is, of course, inevitable with such a book and will affect all the entries that deal with ongoing health service restructuring, clinical conditions, and current treatments. The entries relating to historically interesting diseases, such as gout, are in some ways more facsinating particularly to the medical reader. The section on gout lists some of the prominent English and European figures who have been affected by the condition, such as Henry VIII, Samuel Johnson, and Martin Luther, and features the famously excruciating etching of gout by Gillray, which shows a demon sinking his fangs into an unfortunate sufferer s big toe.

I admit that what attracts me most to this book is its coverage of the literary, cultural, and historical in medicine, and the illustrations, which are numerous, with many in colour. There is a five-page list of Doctors as Authors which will be invaluable for any of us involved in the medical humanities, as not only does it list the individuals but gives an account of the more famous and their works. Keats, Smollett, and Sir Arthur Conan Doyle are covered in some detail. The list of historical entries is impressive; lancets are covered (as a symbol of medicine since ancient times) but no mention is made anywhere of the stethoscope whose development ran concurrently in the history of medicine with the development of cardiology as a clinical specialty.

This book is a very welcome companion on my reference shelf, particularly for the insights and information it will give me on history and culture in relation to medicine. I expect to consult its pages often. Ask for it for Christmas, or better still, buy it for someone in your household to make sure you can get access to it!

Jane Macnaughton

The first Balint group

THIS is a personal story, about my involvement for two years in the first Balint seminar at the Tavistock Clinic, London.

Michael and Enid Balint started their first seminar for general practitioners in the autumn of 1950. This was exactly the time at which a short experience of general practice as a locum made me decide to become a trainee GP, abandoning plans to become a psychiatrist. I had originally entered university to read classical literature and philosophy, but army service during the war caused me to change to medicine. By 1950, I had completed two years of hospital appointments biased towards general medicine, neurology, and psychiatry and was struggling with the MRCP examination.

My atypical preparation for medicine, deficient in the basic sciences, made it difficult to enjoy being a medical student. Indeed I only began to enjoy being a doctor wholeheartedly when I became a GP. I was convinced that the role was important at a time when this was being questioned and when few of my contemporaries made general practice their first choice. For me, I could make use of my earlier education, which had concentrated on people as individuals, their differences, stories, and relationships, and their behaviour in groups.

It seemed to me that there would be no lack of psychiatric problems for a GP. So I was looking for more training to cover what seemed to be the most difficult part of the role. While still an inexperienced, hospital-minded trainee, I joined the other 12 members of the group, with both Michael and Enid Balint, in 1951. I found something different to what I had had in mind.

Michael Balint was by this time 55 years old. The son of a Hungarian GP, he held Budapest doctorates in both medicine and biochemistry, but had trained to be a psychoanalyst within four years of qualifying. He arrived in Manchester as a refugee in 1939 and moved to London in 1945. Although he had been thinking about the psychological training of GPs since 1926, it was his active experience of working with Enid from 1947 in training social workers in the Family Discussion Bureau which provided the most important pattern for the GP seminars.

We met weekly for two hours. Michael would ask: Who has a case? This meant: Who wants to talk about a patient they find difficult? Once one of us had taken up the challenge, Michael would stay mainly silent or ask questions. No particular sort of clinical problem was excluded there was no rule about having to choose a patient with a psychiatric disorder. It took me several sessions before I understood what we were all up to. Small group discussion and what would now be called problem-based learning were both new to me, indeed alarming at times. My companions had the advantage of a few months experience in the group and they had also had much more experience in their practices. Some of them criticised my efforts. There was no fatherly support from Michael (for reasons of principle). Overall, I was not getting what I had been looking for. I noticed that some aspects of psychiatry were mentioned only in hushed tones (psychoses) and discussion of them discouraged. Physical approaches to mental problems, particularly ECT, were actively condemned. So were disease classifications. Despite my previous experience of undertaking a Jungian analysis (ostensibly for my own training), I had the prejudice against anything unorthodox which was then the usual product of medical training. This made me uneasy.

When it came to my turn (there was no routine sequence about who presented a problem next, but it had to be from memory, without notes), I had no difficulty in thinking of patients who worried me. In retrospect, I chose patients with problems beyond my capacity or patients with whom I became too involved and spent too much time. One example was a young intelligent woman, the matron of a home for disturbed children, of which I myself was the medical attendant. She had a variety of physical symptoms, quickly becoming emotionally dependent. Before long she revealed that her brother, an RAF pilot, had seduced her on the day before his aircraft crashed and he was killed. Fortunately, but not before I had become too deeply involved, she agreed to referral to a very experienced psychotherapist and she did well.

It was not long before I realised that the central strand in these seminars was about the relationship between doctor and patient. Moreover, the focus was at least as much on the doctor as on the patient. We had to look at ourselves, and our habitual ways of thinking, feeling, and acting within the consultation, as well as learning to notice aspects of our patients which we had not hitherto thought significant. We learned to listen and observe less selectively.

I have exposed my critical reactions some of which were stirred by other members of the group, particularly when they evangelised as for a new faith. Over the next 20 years my respect and gratitude for a major, international contribution to medical education and practice far outweighed such feelings. Why?

Michael was consistent in his support for the role of the generalist in medical care the continuing personal doctor at a time when such concepts were unfashionable, and when generalism was being replaced by specialisation in Scandinavia and in the United States. He boosted our confidence, not only in that way but also because he

Acknowledgement

I want to remember my colleagues in the first Balint Group: Drs Dorothy Arning, George Barasi, Norman Chisholm, Max Clyne, Arthur J Hawes, Berthold Hermann, Philip Hopkins, Leo Hornung, Aaron Lask, Paul R Saville, George Szabo, Jindrich Tintner and Anneliese L Zweig.

Very few of us are now living.

The work of this group is very fully described in: Balint M. *The doctor, his patient and the illness.* (Second edition.) London: Pitman Medical, 1964.

encouraged us to assume more clinical responsibility. He rarely offered to take over a difficult problem. Indeed, he led us to see the uselessness or the dangers of some referrals; they might temporarily relieve the GP of responsibility, only to return it to him later, more complicated, yet unresolved. These he described as the dilution of responsibility and the collusion of anonymity two of the pregnant, useful, and memorable phrases for which he had a special gift.

Among these phrases the most basic and the most frequently valuable was (and remains): If you ask questions, you will always get answers, but hardly anything else . I had never been taught before to listen before questioning and to listen without interrupting, if possible, to the complaints, the words used to describe them, and the fears that might be implied in them.

I learned the practical value of the long interview, especially in a difficult relationship with a patient, and the limited value of reassurance unless the exact source of anxiety is targeted. I learned to recognise more quickly my own emotional reactions, whether to an aggressive or to a flattering patient, and to accept them as an important part of the case to be dealt with.

I believe that the seminars made me better at my job, but cannot prove this. I would certainly claim that they helped me to deal with unusual or difficult people with less anxiety. The Balints declared that the focus of research was on the processes in the doctor patient relationship, which cause both patients and their doctors unnecessary suffering, irritation, and fruitless efforts. Their declared aim was to help doctors to become more aware of psychological influences and to gain more understanding and control of their own behaviour. They challenged some of the well-established beliefs and practices handed down in teaching hospitals, particularly the bias in favour of physical suffering. But they pointed out that their exploration of the important, neglected area of mental or emotional suffering could provide only limited understanding and guidance.

It was only a small minority of GPs who recognised the potential of the Balints work. For about 20 years they and the GPs who worked with them in the seminars were objects of suspicion. If I claim that this changed by 1972 with the publication of the RCGP book: *The Future General Practitioner: learning and teaching*, it has to be added that the book was at first disowned by the College Council of the time, before becoming a standard text. Fifty years later, many of their ideas and methods have been become part of prevailing teaching and practice or are being re-invented by people who have forgotten their source.

John Horder

RCGP 50th anniversary celebrations

THE RCGP has launched its programme of events to mark its 50th anniversary. Throughout the year, the events will celebrate the strengths of general practice today and anticipate how family medicine will evolve.

Golden anniversary celebrations officially commenced at the College s annual general meeting on 16 November, where the College launched the commemorative hybrid tea rose that was developed exclusively for the RCGP. Representative of the compassion demonstrated by primary care staff, the rose, named Caritas will be exhibited at the Hampton Court Flower Show in 2002 and is available for purchase by GPs and the public. The RCGP seminar The College: Past, Present and Future on 17 January 2002 will examine the evolution of general practice to the present day, the creation of the RCGP, and the key role it has established since its foundation. Current and future issues faced by general practice and the medical world, as well as the role the College will develop in the future will also be explored.

On 12 13 April 2002, the RCGP annual Spring Meeting, hosted by the Midland Faculty in Birmingham, will commence with a golden anniversary dinner, providing an opportunity for College Fellows and Members past and present to celebrate 50 years of the RCGP. Speakers include Indarjit Singh, Director of the Network of Sikh Organisations, who will reflect on the humanity and spirituality of general practice. A special lecture will examine how the past 50 years have led general practice to its present position.

National GP Week (23 29 September 2002) will be supported by medical organisations, including the General Practitioners Committee of the BMA, the NHS Alliance, and the Overseas Doctors Association. This week will celebrate the work of all primary care staff and provide GPs with the opportunity to highlight issues they are facing and build stronger links with the public.

Other golden anniversary highlights include a major conference for GPs, WONCA Europe 2002 , that will be hosted by the RCGP in June. The fifth John Hunt lecture will take place on 24 January 2002, and the RCGP will participate in the London open house weekend on 22 September 2002.

Visit the RCGP website at **www.rcgp.org.uk/50th/index.asp** *for full details of all events.*

Accredited Professional Development

The RCGP has recently signed the sponsorship agreement with MDU for Accredited Professional Development (APD). The programme will be launched nationally in April 2002. Members can sign up from January 2002 onwards.

A little bit about APD…

The paper-based programme is being finalised while an electronic version (which will be available initially on CD ROM at launch) is being developed. APD will be accessible via the RCGP website in due course.

The programme has been designed to help GPs build a portfolio of all the information and evidence required for their annual appraisals and revalidation across a five-year cycle, based on their everyday experience, in a way that suits them and which fits in with their practice needs.

APD provides guidance on revalidation and helps GPs to plan their learning, demonstrate the quality of their practice, and celebrate their achievements. Individual GPs will be supported by an APD Facilitator who will help them identify their educational needs and guide them through the process.

APD participants can also include parts of their portfolio towards FBA, MAP and other College Quality Awards.

Contact points…

Professor Ruth Chambers is National Convenor for the programme and Sarah Lantry is temporary Project Manager. Sarah See will be joining the College as Project Manager on 2 January 2002.

Our aim is to help as many GPs through the revalidation process as possible, and I envisage that APD will cause significant interest among GPs. We ll be receiving enquiries from RCGP members, MDU members and GPs nationwide and I would be grateful that if you do receive an enquiry about APD that it is passed on to a member of the APD team quickly to maximise efficiencies across the College.

If you receive an enquiry about APD, or would like any additional information on the programme, please contact Sarah Lantry, temporary Project Manager (APD) by e-mail: slantry@rcgp.org.uk; or tel: 020 7581 3232 extension 252.

Sarah Lantry

rcgp 50: events

17 January
The RCGP 50th Anniversary Seminar: The College, Past, Present and Future (by invitation only)

24 January
The Fifth John Hunt Lecture London Venue (details to be confirmed)

12–13 April
50th Anniversary Spring Meeting
Lyn Shields, International Convention Centre, Birmingham, hosted by Midland Faculty, 0121 486 1157 (booking form can be downloaded from Spring Meeting website at **www.rcgp.org.uk**)

9–13 June
WONCA Europe 2002 Conference in London. Closing date for abstracts 7 December 2001.
(**www.woncaeurope2002.com**)

July
President s Reception for Retired Members (by invitation only)

RCGP Wales 50th Anniversary
Informative Day on The Citadel and visit to the Big Pit.
Contact Nicola Peachey, 02920 504038 (details to be confirmed).

22 September
The Observer London Open House Weekend

23–29 September
National General Practice Week

RCGP Scotland 50th Anniversary
Events: Series of peripatetic Lectures of five nights of one week in each of the five Scottish Faculties.
Contact Gill McDonald 01786 447841 (dates to be announced)

50th Anniversary events planned by North Wales and South West Wales Faculties

15 November
AGM 2002

Unless otherwise specified, further information is available from Regina Gonzalez at the RCGP, 14 Princes Gate, London SW7 1PU (tel: 0207 582 3232 extension 248, email r g o n z a l e z @ r c g p . o r g . u k rgonzalez@rcgp.org.uk)
w w w . r c g p . o r g . u k / 5 0 t h / www.rcgp.org.uk/50th/

neville goodman

NHS University

How s this for a plan? For too long, baggage-handlers at airports have not been able to fly aeroplanes, the staff in the coffee stalls to control air traffic, and the people who drive the buses across the tarmac to service jet engines. My plan is for a central college for air travel. Everyone who wants to work in an airport will come to it. There will be classes for navigation, the theory of jet engines, how to use a coffee percolator, how to stop planes colliding in mid-air. Mix and match your classes properly and you could be the first air traffic controller who is allowed to clean out the toilets in the First Class lounge. Well, it makes just as much sense as the NHS University.

The much heralded NHS University, its prospectus launched in mid-October, is a daft and dangerous assault on medicine and knowledge. The prospectus was supposed to be on the Internet, but I couldn t find it. I found a press release from 10 Downing Street (16 October 2001) and a report in *Guardian Unlimited* dated the next day. If what is in them is anything to go by, the prospectus (apparently sent to all prospective chief executives of the new body: I didn t receive one) will make interesting and disturbing reading.

Mr Blair announced this biggest university in the world would provide professional training for everyone from cleaners to surgeons, thus downgrading the word professional much as adult movies degrades the word adult. My dictionary defines a university as a high-level educational institution in which students study for degrees and academic research is done . A DoH spokeswoman explained that the term university had been chosen because the title was associated with the best in British education and the government wanted to ensure the new institution provided the best possible training . Universities are not about training. And I m not aware of many PhDs in the ordinary routine of cleaning floors or serving out meals, however important those staff are to the everyday running of the NHS. The Downing Street press release actually states that this new university will enable NVQ qualifications. Mr Milburn s blather included rhetoric about helping staff to smash through the glass ceiling which holds too many back . It seems more likely that it will bring those above the ceiling crashing down.

At least clinical governance and NICE, flawed though they are, are attempts to solve generally accepted problems. The NHS University is an attempt to solve only one problem: the stubborn resistance of doctors to the idea that politicians know more about health care than we do.

Nev.W.Goodman@bris.ac.uk

Miguel Torga

Diaries, 1933–1976

Introduction

IMAGINE a writer born in a country that once took all its myths from its navigators, from the shifting mirror of the sea that transported them to the other side of the world, and whose most famous twentieth-century poet was a man with an entire wardrobe of sailor-suit identities (Fernando Pessoa). A revelation, then, to discover a writer of international stature, like Miguel Torga, who never abandoned his lifelong commitment — his 'impenitent communitarianism' as he called it — to the peasant traditions of a part of the world that could almost come from the pages of Hesiod.

Civil name Adolfo Correia Rocha, Miguel Torga was born in the village of S. Martinho de Anta in the province of Trás-os-Montes, the poor mountainous north-east of Portugal. At the age of 12 he left school and went to Brazil, where like a good autodidact, he read himself into world literature. He published his first book, a volume of poems, in Coimbra in 1928, five years before starting the diary that opens with his graduation as a doctor. He worked for the next 40 years around Coimbra as a general practitioner and ENT surgeon, putting up, more than once, with the unwelcome attentions of Salazar's secret police who confiscated his papers and passport. For Torga was a traveller too: he interrupts his remarkable observations on the 'transmontanos' with dispatches to himself, as it were, from the European capitals and North Africa. He saw nothing paradoxical about this — "it's as if every horizon where I'm a stranger restores my integrity". Humans are not trees, but we need roots, roots in something other than the purely social. Torga described his own rootedness as 'telluric': a life of work, he said, was the only possible life for someone from the land. His attachment had nothing inhibited or folkloric about it. His diary shows him to have been acutely aware of the effects of poverty and illiteracy; of the gulf between the spiritual solace of naïve tradition and the material comforts of a civilisation which, armed with a belief in autonomy, unaccountably loses face in collective panic. There is progress, and there are its ironies too. Torga hoped for what he called 'the accession of small countries to universal dignity'. It is worth pondering that word 'universal': it doesn't mean the same thing as global, which Portugal's *marinheiros* can be said to have invented as an adjective in the 15th century. "The universal", according to Torga, "is the local without the walls". In a world becoming more abstract by the day, that is a position of radical good sense.

Nominated several times for the Nobel prize, Torga completed the last volume of his diary, *Diar o XVI*, in December 1993, when he himself was ailing. He died in 1995, leaving almost a hundred stories, some of which are available in English as T*ales and More Tales from the Hills*, two novels, three theatre pieces, much poetry, and the remarkable *Creation of the World*, also available in English translation. Perhaps it is not too much to hope that someone more intimate with Portuguese might be moved to translate every one of his compelling diaries: there can be few other modern commentaries where a doctor's traffic of empathy is part of a more meaningful whole.

Iain Bamforth

Above and left: maps of Portugal and the region surrounding Coimbra, including Vila Nova.

Miguel Torga

Diaries, 1933–1976

Coimbra, 8 December 1933
So now I'm a doctor. As tradition demands, at the moment the master of ceremonies intoned 'yes', and the professors and dean authorised me to administer enemas to mankind, a group of strangers and familiars 'plucked' me from top to toe. All they left me was my academic cape. And I had to walk through the town in this gear, as close as I could be to my own reality: a naked man wrapped up in three metres of darkness, and the body shaken by a deep fright, and nobody knows where it comes and where it goes.

Vila Nova, 7 November 1934
Today it ended. And as always, there I was, completely at a loss. Even when it was no longer possible to have the least illusion, I still clung to it and ... I hoped. It's something I've never been able to destroy in myself: the idea that a being, from the moment it is born, has the right (and the obligation) to live for sixty years on average. At least, the sixty years of the average. It often happened, when I was holidaying with my father, that I helped out with the harvest. Then to see the corn, or the linen, growing. And even while knowing that their lives were only for a season, to go and visit the furrows next holiday, and be upset to find out that instead of linen or corn there was a large square of potatoes.

"What about the linen that was growing here?"

"We gathered it in August, son!"

In August, it is true, the linen ripens. For the few months nature provides, it takes all the heat from the sun and gorges itself. Then it shows signs of fatigue and dies.

But this little child hadn't tasted the sun yet. He was in the first week of his life. He wasn't yet at the age where the stalk is perfectly fibrous, the flower a delicate blue, the grain a ripe brown. That's why, when I went into the bedroom, it was the most painful feeling I've had in my life. He was there, not yet replaced by the barley or the rye, but just about to be. The mother was in tears. And the child, white-faced, discreet, face to the wall, turned his back on the useless drugs scattered on the night table.

A doctor can't even weep. He can only take the thin little arm, still warm, hold his hand to the inert artery and clench his jaw for a few seconds. After, it only remains for him to go, without so much as a word.

Who knows the words that are needed in moments like that? Words that a doctor can say to a mother who has given the world a living son and who receives from the world a dead child.

Vila Nova, 10 February 1935
I can't anymore. I can't spend my life doing that — playing cards with the priest, getting up who knows when to see a patient at Gandramàs and the rest of the time lending an ear to some hunting story or even telling one myself. I'm worth what I'm worth, but this isn't the life I deserve.

Vila Nova, 15 July 1936
A delivery. By dint of needles, forceps, in the midst of cries and the tears of the entire village, but a delivery all the same.

An animal with big legs and blue eyes. One called Newton.

As soon as his son had been pulled into the fallen world his father, don't ask me why, decided to call him Newton. Newton and nothing else.

And the employee at the registry office — a colossus of erudition — thought the father was overdoing it. Newton! Well, well! But I confirmed it. Newton, what of it?

Spade in hand, this new little man will definitely not discover another law of universal gravitation. But he will certainly discover suffering and, in my opinion, that is enough to give him the right to carry, on this earth, any name at all.

Coimbra, 19 January 1939
While I was operating, between two loud groans, Fonseca told me his life. His father died when he was ten; then his mother when he was fifteen. At nineteen, he broke his leg and three ribs after falling from a cart. At twenty, he had a double pneumonia. One of his sons died when he was twenty-four; his daughter when he was thirty. At thirty-two, he caught typhoid fever. He was thirty-five when his wife died. And now, in the space of five months, he is going through his fourth operation. At the end, he asked me:

"Tell me, doctor, is that a fit life for a man, that?"

"Well! Yes."

Coimbra, 22 June 1942
Someone said to me today: "Dear chap, if you could be in the literary life what you are in the medical life — conciliatory, tolerant, ready to forgive — it would be a marvel!"

The poor man had lost sight of the difference which exists between both these lives, both sacred for me. As a doctor, I look after suffering brothers who knock at my door, to whom I owe love and assistance; but as a writer I fight against hypocrites, fat and in good health, who consider art a means for reaching grubby and hidden ends.

Coimbra, 11 March 1943
She had made an effort, held herself proudly, rouged the pallor of her face with a little life which clearly didn't belong to her anymore, and she said to me brusquely:

"Don't you recognise me?"

"Off the cuff, I must confess..."

"I'm Beatriz ..."

"Excuse me, but ..."

A cloud of disappointment eclipsed my surgery. Then everything was clear again.

"Beatriz Pitaça!"

"Yes! You remember now!"

"But of course!"

She could hardly hold herself erect but nevertheless stood standing there, and something adamantine in her pupils reflected her resolve.

"Well, well, have a chair ..."

She hadn't heard. What residual energy she possessed refused to capitulate without glory.

"Antonio Vilela's daughter. Gonçalo's wife ..."

"I know, I know. But you've lost a lot of weight..."

"It would seem so ..."

The black cloud returned and this time stayed a little longer. With the flicker of life gone her bony face fled that very instant to the world that already claimed it. She staggered.

"Now, now! What's come over you, do have a seat ..."

She slumped down on the cushions like a marionette suddenly cut from its strings.

"Well?"

A weak groan emerged from the clothed cadaver.

"I'm very ill ..."

"Come on! It's just tiredness. Let me feel your pulse."

She shook her head sadly. Then she began to stare melancholically at the pale remains of the day that lingered in the room.

"I'm done for. But I don't want to die just yet ... I want to live a little while longer..."

A new surge of energy caught her. Her eyes shone as they had when she came in and her entire being tautened with intent.

"I'm not forty yet..."

"You'll live to be a hundred. What's troubling you?"

Now she was no more than renunciation.

"A terrible illness. I'm rotting away inside ... A devilish tumour. They opened me up, took away a kilo or two of flesh, but it's even worse than before."

Leaving to one side the accusation

she had made against her illness, one would have said that it was the cancer itself talking in that thick, tired voice.

"But they'll operate on you again, and you'll be alright."

She replied with a strangled voice.

"I won't have the strength to go through with it ..."

"Of course you will! My word, one wouldn't think you're a woman from the mountains! You've come all the way from the deepest neck of the woods full of courage and now you're scared?"

"Yes ..."

The silence of death chilled the room for a little while But life returned with a lighthearted and quite ordinary bit of banter.

"Tell me, Beatriz, did you come by train?"

"Yes, I just slumped back in the seat and here I am ..."

And then, as if electrified:

"And why don't I want to die yet? There they were all saying to me: 'don't go, you'll have to stop on the way; it's better to wait for it peacefully at home.' But I said to myself: I'm going to go all the same ..."

A flame, it seemed, was burning on its own.

"And your husband, why didn't he accompany you?"

She became even paler.

"He is dead. Don't you remember?"

"Oh yes ... True enough. But your father!..."

Then her face hardened.

"We don't get on. I went through the operation there, and he never once asked me if I were any better or worse! He doesn't think any more of me than he would of a dog ... And he is going to inherit everything ..."

"You don't have any children?"

The furious expression changed into a resigned sadness.

"Alas no ..."

"Well, don't talk any more, it's tiring you. I'll look after everything, and we'll see if things aren't better afterwards."

The ghost of a vague smile flitted over her hostile death's head for a moment. She murmured softly:

"If only that could be true ... What I've is like a stone. It's hard, hard..."

She put her hand on her belly and once again the death's head took possession of her face. Two tears started down the creases.

"Come on now! Now that's sight! You're crying! Come, come, gently now!"

"This time I'm not going to survive it ... I've a notion that I won't return to San Martinho ..."

"Don't be silly ..."

"Precisely. I'd like you to promise me something now, this minute ..."

"Whatever you like ..."

"Should I die, don't give my father this bracelet and this money I've with me ..."

"And what should I do with them?"

"Go to mass. Say mass for my soul and for my poor Gonçalo's. I picked quarrels with him a lot when he was alive. And even afterwards ... I thought it was his fault that we didn't have any children ... But no, the poor man. It was already this bloody cancer..."

Coimbra, 28 April 1943

If the roof of the old hospital building hasn't collapsed it's because old things are more resistant than one imagines.

It was the admission period. The form required short, concise replies.

"Profession?"

"Prostitute."

"Children?"

"Eight."

"How many?"

"Eight."

"And all since ...?"

"All of them."

As serene as if she had said something of no account, she remained standing, leaning against the wall.

"Have a seat."

"Thank you."

She took her swollen abdomen between her hands, found a place on the bench and continued to answer the questions.

"Abortions?"

"None."

"None!"

"That's right, sir."

"With the life that you have, it's ..."

"No. I never wanted an abortion."

"And your children? Alive or dead?"

"All living and in good health."

"Raised by yourself!"

"Of course!"

The writing on the registration form wobbled, uncertain. But this unfortunate woman was calm and steady, her admission form for the maternity ward properly and duly completed.

"Very well, please go up."

And number nine was born, like the child of any honest mother. The mother in confinement left her bed this morning. "I'll send you some business", promised a colleague, confused in the face of such grandeur. Then he added, addressing himself to me: "I want to help her. All that is a life of misery, but in the face of such purity one has to bow and admit defeat."

"I find it good that you want to be her protector", I said to him, looking him squarely in the eyes. "But if you really want to help her, follow her example and, even defeated, you won't bow down."

Coimbra, 1 February 1945

Penicillin. I too want to try out the last panacea invented by science. On a young boy burning up with fever, pus running out of his ears and terrible pain. In the old days, the tympanic membrane would be doused with milk from a wet nurse which cured it radically. Now it's penicillin. When I went to look for it in the house of a patient who had some left over, the father didn't want to let go of his treasure. He was in possession of a talisman of health, and he didn't want to sell it or to give it to anyone at all. He was drunk: perhaps that was why he believed with a supernatural force in the magic of this drug. His wife, who was steadier, intervened and they finally gave me the holy viaticum. At my other patients' house they were waiting for the miracle treatment in their prayers. And I gave the injection, both in humility and in humiliation. On one hand I knew that the yeast in question would have become ridiculous fifty years hence; on the other I knew that it represented the highest point so far reached by the ingenuity and hope of man.

What would you say about that, you Greek philosophers, who didn't believe in achievements! You who restricted yourselves to speculation, comprehension, beauty and natural health!

Coimbra, 18 November 1947

For an artist, the wish to be applauded is more a need than mere vanity. It is the feeling that he is necessary, that he is loved. What could be more paralysing than to spend the entire day in this surgery, waiting for patients, who pass my door on their way to consult my neighbour? To write for posterity has never stimulated or consoled anyone. The legitimate prayer of every artist, whether he admits it or not, is: give me, Lord, a little glory while I'm still alive.

Coimbra, 18 March 1949

The last client has just left. It is six o'clock in the evening and since nine this morning I've been floundering in other people's misfortunes. But now I'm free: I'm watching the sun set on an avenue full of life, and smoking a cigarette that has a good taste of life, even if it not doing me any good. I've the time to go to a lecture but I'm going to skip it! Who cares right now what happened in Florence at the end of the Middle Ages? As far as human misery goes I had my share today. I've dried tears, relieved pain, treated what I could, by direct help, without philosophy, without ulterior motives, beyond history. Blood welled up and I stilled the haemorrhage, that's all.

“She slumped down on the cushions like a marionette suddenly cut from its strings.”

Miguel Torga -
Diaries, 1933-1976

In a moment, when night falls (and it's almost here) and I've returned home, it may happen that out of force of habit I shall forget the reality of what I've lived today and sit down to read about culture and the past. But first I make a point of smoking my cigarette.

Montesinho, 28 September 1951
I've been called to the bedside of João Gata who is the oldest and most gnarled human stock in this community. He's ready for death, and he's dying in his bed. Just under the room in which his death agonies are taking place two cows provide a heavenly music for him with their cattle bells.

Coimbra, 16 December 1952
The unholy pact that grows unbidden between patient and doctor drives me to despair. I try to elude it, to free myself from it, but I can't do it. My poor patients insist on it, deliver themselves to me, trust me implicitly, and I'm obliged to take their life in my clumsy, powerless, human hands. "You, you know the answer, doctor! So, please, tell me!" Away with you! Can a black sheep like me really assume the responsibility of preserving for them a life continually under threat? "It's nothing really; of no importance. Rest easy!" Do I know if it's important or not, if it can be treated or not, if the poor patient is going to die or not!

I don't have the force to get used to the routine, to sleepwalk under the professional mantle; each consultation, even though I'm already an old hand at the job, is still a initiation rite, a smiling martyrdom. Yes, I smile, and inside I eat my heart out. Unable to stick the standard treatment stamp on the envelope of symptoms, I stop, indecisive, at harm's crossroads; puzzled by its fatality which, in the best of cases, is only ever deferred.

For twenty years I've been earning my daily bread this way; I practice medicine. The white coat, an *ersatz* surplice, makes me look as driven white as a deacon. But inside myself, sceptical, more and more sceptical, I'm like an atheist leading the mass.

Coimbra, 2 March 1953
A full day. From nine o'clock this morning to seven this evening, I've strewn reassuring words! My throat is sore, but I'm going to close my practice with a clear mind. The depressed young man ought to fight back, the girl in love ought to find her lover again, and the man with the ringing in the ears ought feel better with a little bit of resignation and the pills I've prescribed.

It's good to be doctor and writer at the same time. One can give twice over. Young people come to see me because I write poetry, older people come because I can treat them, and we all benefit. They cease feeling alone in the world, and so do I too ultimately. That's how I get through my day, doing things devoid of any dramatic heroism, things that are useful and modest; and which suit my natural shyness, which tends to camouflage itself behind intellectual and physical violence of a compensatory type.

I've even got to the point of wondering if I could exist just as a writer, and live without this commitment of the body, without this communion in pus and tears that my poems try to sublimate. When I open my bazaar in the morning two voices inside me argue the toss. One speaks bad of my lot, the other good. But when I've succeeded, like today, in rekindling a few vital sparks, then in the evening both my voices are reconciled.

S. Martinho de Anta, 13 December 1953
Here I am fighting for the life of the last root left to me. My father has had a cerebral haemorrhage and I've come to help him. But lying there unresponsive, his mouth twisted, my old man looks as if he's smiling ironically at my distress and my drugs. It even seems as if, already arrived on the other side of the river, he's confining himself to observing whether I like it or not the tragi-comic spectacle of the human being in action. A kind of black passivity, that makes me think of a watch that has stopped although it still seems to be telling the time.

But I act as if nothing was amiss and, with all the serenity I can muster, I weep inside and press on outside. What can a son do other than stay faithful to his roots; and what can a doctor do but look after others? Anyway, when a watch stops the only thing to do is wind it up. Even if it continues not to work, it takes on our energy and that protects us from its rude inertia.

Coimbra, 6 April 1954
Just when I was about to date this note, instead of 'Coimbra' I wrote 'recipe' ...

Coimbra, 30 April 1954
What secrets are sunk in the four walls of a surgery! And what a human responsibility I took on the day I opened this confessional! Modest and careworn servant of a temporal religion, I've had to greet the most insistent pains, the most secret intimate details, the most unsettling doubts. And I've had to find a way of prescribing hope for all that! From the empty sack of my individual poverty, I've had to draw miracle remedies: of optimism, faith, illusions. The miraculously treated persons, in exchange, have left my office lumbered with ghosts. Skins of the unhappy beings they have, in this very place, sloughed off.

Coimbra, 10 December 1958
Twenty-five years now that I've been battling death professionally, and I feel more incapable than ever of understanding and accepting it. Halfway between the peasant in the pure state and pure intellect, when death comes calling I find neither the peace of the credulous person who regards the slow decline of his existence as a natural cycle nor that of the intellectual who interprets life in terms of mental categories. Whenever I spy death at a patient's bedside, I always react in an instinctive and precipitous way. Without waiting to hear more, I set about combating it tooth and nail, with all the means at my disposal. I exhaust the arsenal of the pharmacopoeia and of hope. And in putting myself almost physiologically in the patient's skin, and in making use of all the treatments science puts in my hands, I fight until I'm exhausted. And when it's death that triumphs, I accept my defeat — but only pragmatically. Conquered but not convinced, I steady my knowledge and my resolve, and prepare myself for the next combat. And that'll be the end of me, saying no to death.

Coimbra, 20 January 1961
The query is always the same, but the length of the reply depends on the time at hand and my self-possession.

"Medicine produces lots of writers! Do you know why?"

Patiently, I fold the prescription, take off my glasses, stand up and begin the sermon which, today, comes to me in fits and starts:

"It's not medicine which produces them. Medicine limits itself to maintaining the gift in those who're born with it, and that is no small thing. Unlike other professions which stifle in the individual the spirit that accepts and comprehends its kind, medicine does the contrary. The doctor *qua* doctor cannot close the doors of his soul, extinguish the glimmer of his understanding. All kinds of humans seek out his help, at all times of day: those who're suffering and those who're simulating, those who're afraid and those who're gone in their minds. A certain emotional and intellectual dimension is required to be able to respond effectively to so many types of

calls. Now, this very dimension is implicit in the condition of the artist, the most receptive and the most perceptive of mortals. So when chance imposes a creative vocation on a condemnation to the clinic, there's no terrible conflict. The pen that writes and the pen that prescribes switch over harmoniously in the same hands."

Coimbra, 8 October 1963
My long experience as a doctor teaches me not to despair of the national lethargy. Collective bodies, like individual ones, give themselves over from time to time to a sort of aboulic voluptuousness, apparent death, for which there seems no cure. But, in the intimacy of the cells, metabolism continues. And at the most unexpected moment, the moribund opens his eyes, talks, reacts and resumes a normal life. Nations, also, sometimes rise up from the tomb.

Coimbra, 14 October 1963
Humankind is still very far from wisdom. It may even be asked whether, in some fields, humankind wasn't closer to it in the past! In medicine, for example. All that the masters and manuals teach about reality to an Asclepius of our time is never more than poor appearance. I've spent years learning to observe and to treat patients. But I've learned to observe and treat them only from the outside. A wound? Disinfectant and dressing. A nervous breakdown? Tranquillisers. Fever? Quinine. Well, things aren't as simple as that, as I'm finding out for the millionth time. I receive patients in my practice. One enters and the other leaves, and so on. Faces known and unknown, agreeable and disagreeable, young and old. As an attentive inquirer, I ask questions, I examine, I conclude. I go from symptom to symptom, suffering to suffering, life to life. I promise recovery, improvement, I prognose death and I give words of hope as an added extra to all my prescriptions. But even when I see myself as efficient, I feel frustrated. I'm fully aware of being in the process of swimming on the sand, two steps away from a vast ocean. I can see perfectly that I'm applying logical rules to an illogical game, that I ought to be on the other side, at the centre of the world in disorder — or so it appears to me — of illness. But there's no room there for my well-ordered reason, which tackles methodically what has no method, which knows before having learned. I respond to the claims of dramatic uncertainties with bits of well-established evidence, I argue objectively against subjectivity, I fill with peremptory affirmations the intervals of doubt that two or three tiny failures of logic have left gaping in the conversation. And what saves me is the blindness of my patients who, in their desire for cure, mistake chalk for cheese. These souls in distress have knocked at the door of the great sorcerer and listen to him with complete confidence, piously convinced that all he says he has puzzled out at the bottom of the wells they're drowned in. They do not even suspect that the magical formula is invented, manufactured in panic, and that it makes me laugh when other sorcerers, trained in the same school as myself, chalk it up to my account.

Coimbra, 21 December 1966
Instead of the electric shock he was expecting, I gave him a kick in the backside and treated him in my own way:

"If you don't want to be in the despicable position of being a bourgeois with a clear mind, then have the courage to be a troubled man."

My medical miracles are very simple: I act in such a way that deserters rejoin their unit.

"Medicine produces lots of writers! Do you know why?"

Coimbra, 25 March 1969
I didn't find any other symptom, but the sentence he came out with was all I needed to establish a diagnosis.

"The world...", he said, "— seen it all."

And I concluded that he was at the end of the road.

Unable to come up with any treatment better adapted to this mortal satiety, at least I attempted to starve him with my own hunger:

"Oh really! Well I haven't finished seeing Portugal yet."

Coimbra, 20 March 1971
I shall never forget this wild cry of terror: "There it's coming! It's coming! There! Now!"

I gave another injection of adrenalin to stimulate the heart, I did cardiac massage and mouth to mouth. In vain: the man was dead, irremediably. Now he was no more than a heavy cadaver, in the process of cooling, gradually stiffening, like so many others I'd not succeeded in keeping alive. All that was left was to forget this incident, to return to my papers; in any case the patient had been expecting another doctor and my intervention took place only by accident. But there was this disturbing fact: the vision and the panicky fear. The horror-stricken dread before a spectacle that no one could see. And that's all I continue to think of, moved, disturbed, the words of the dying man furred up in my ear. What did this man see? What does the face of Death look like?

Coimbra, 6 November 1974
Entire day taking refuge in my surgery, progressively deserted by clients. The sun floods my office, outside the traffic rumbles by, and I read, edit, laze about, freeholder of my solitude. Life is taking leave of me and enlarging little by little the void that surrounds me. And inwardly I thank it for preparing me the sedative of dying gently in this hole, which started out as a place that was unambiguously businesslike and is now visited only on occasion, by the faithful few. Which makes me think of these detective agencies that put a commercial name on their door, but only as a front.

Castro Laboreiro, 17 July 1976
One of those doctors who stands helpless beside a dying person and feels the pulse slip away gently, with a troubled finger ... Over the years I've witnessed the gradual dilapidation of this place. For centuries, it knew how to preserve, unaltered, sacrosanct human and social values. Today, all it can guarantee to its visitors is the purity and authenticity of the air they breathe and the water they drink. All the rest is degenerate. The character of the buildings and the costumes, the agricultural and pastoral practices. It is here — and at Vilarinho das Furnas and at Rio de Onor — that I saw for the first time God's creatures in their abundance, conjoined and free. And since Vilarinho das Furnas has disappeared from the map, submerged by a reservoir, my impenitent communitarism has sunk new roots at Rio de Onor and Castro Laboreiro. I persist in making these visits, even if I'm more and more disenchanted. It's an article of faith for me that humankind will finish by reacting against the mass globalisation we're heading towards. Reason and instinct will finally tell us that all the plastic flowers in the world aren't worth the lilies of the valley, that all the laboratory chemicals aren't worth a fermenting cartload of dung, that all the imperious whistles of progress aren't worth the cordial gong of a cattle bell. And at this hour of salvation — which shouldn't be a long time coming since the longer it takes the worse it'll be — we'll rediscover these sanctuaries, rebuild them and give them back their dignity. That's why I suffer without losing heart when I see them collapse. My hope is in their foundations.

Excerpts from Miguel Torga, DiÆrio I-XI, Coimbra, Portugal; translated from the Portuguese by Iain Bamforth.

our contributors

John Bain is professor of general practice at the University of Dundee. He plays golf with deadly seriousness and effect

Iain Bamforth qualified as a doctor from Glasgow in 1982. He lives in Strasbourg, France, and is presently compiling a history of medicine as told through literature
IainBAMFORTH@wanadoo.fr

Rosie Donovan is a Glasgow-born photographer who has lived in Canada since 1972. She works exclusively in black and white, using available light

Edzard Ernst is professor of Complementary Medicine at the School of Sport and Health Sciences, University of Exeter **E.Ernst@exeter.ac.uk**

John Frey is professor of Family Medicine at the University of Wisconsin Medical School, Madison, Wisconsin in the US **www.fammed.wisc.edu**

Neville Goodman is a consultant anaesthetist in Bristol, a freelance medical editor, and joined the Labour party well before it became New
Nev.W.Goodman@bris.ac.uk

Denis Pereira Grey is a multiple Ex ex-chairman of UK Council and ex President of the RCGP. He has edited the *BJGP* and the RCGP s *Occasional Papers*. He is presently Chairman of the Academy of Medical Royal Colleges

Iona Heath is a GP in the Caversham Group Practice in London. She presently chairs the Ethics Committee and the Health Inequality Working Group of the RCGP

Paul Hodgkin works as a salaried GP and in addition runs Primary Care Futures as a freelance consultant.

John Horder is the co-author, with Stephen Pasmore, of *14 Princes Gate: Home of the Royal College of General Practitioners,* available from the RCGP at a price of £8.50 (non-members: £9.35)

John Howie was the world s first professor of general practice and retired from his post at the University of Edinburgh only last year

Sarah Lantry is Project Manager for Accredited Professional Development at the RCGP, **slantry@rcgp.org.uk**

Irvine Loudon DM(Oxon) FRCGP was a general practitioner in Wantage, Oxfordshire from 1952 1981. He is now a medical historian who has written seven books and published between 40 and 50 papers on historical subjects in refereed journals. He is an Honorary Fellow of Green College, Oxford

Jane Macnaughton is Director of the CAHHM at the University of Durham
http://www.dur.ac.uk/cahhm

George Davey Smith was a member of the multimedia noise-assault combo Scum Auxiliary in the early 1980s, but since commercial and critical success eluded the group he has since worked as a social epidemiologist

James Willis is presently climbing mountains in South Island, New Zealand

james willis

The last word

You ought to try cleaning windows if you think you have the answer.
You see, we had just had the window cleaners and I thought it was they who had left the marks I criticised this morning on our bedroom window. My mistakes were first that the marks were on the inside, not the outside where the cleaners had cleaned, and second that I didn t know my wife had already had a go at them.

A bad moment

Actually, I do know about cleaning windows. I have done it myself, in the past. I have theories about it: The way minute imperfections can, in the right atmospheric conditions, become loci for condensation (I confirmed this morning, too late, with my finger tip, that what I had seen was condensation). The way such marks can be further highlighted by a particular, unfortunate inclination of the morning sun.

In laboratory conditions, *in vitro* (as we scientists put it), such imperfections might be eliminated, but *in vivo*, a window cleaner s job is never done. The key to dealing with window cleaners, I humbly conclude, is to respect the difficulty of their job.

The key to being a good doctor is to respect your patients. The key to being a good teacher is to respect those you try to teach, and that means being willing to be taught by them. The key to being a good Royal College is to respect your members, and that means remembering that when each one of those members is in surgery, one to one with a real patient, they are doing the real job, and that everything else is infrastructure. The key to being a good politician, bearing executive responsibility for a great profession which is composed of highly-selected, highly-educated, highly-motivated individuals, is to respect those people, and to acknowledge hidden difficulties in what they are trying to do.

As David Misselbrook points out in his wonderful new book, *Thinking about patients*, doctors have a need, and a feeling of duty, to dominate their patients. It seems to me that the Royal College has made the same mistake of wanting, and feeling it ought, to dominate its members, especially its young aspiring members. And now that the government has chosen to assume, or has felt obliged to assume, the role of *dottore di dottori*, it has slipped into the stock characterisation it enjoys dominating, but also feels it must dominate, the medical professions. And like the College, its exemplar, it has used managerialism, that tragically alien and inappropriate tool.

Treating patients with true respect may seem to threaten the doctor s authority and therefore his or her effectiveness. But modern doctors, practising patient-centred medicine, have made the discovery that this is an entirely unfounded fear. Their patients respect them even more for their openness. There is something beyond the old mystery which the patients need as much as they ever did.

Doctor-teachers, similarly, wonder what they have to offer bright young graduates, but when they show the learners respect they find it reciprocated with interest.

Perhaps this is the key to the re-invigoration of our College in its second fifty years: for it to become individual member-centred, as it was at its foundation, and thus to set an enlightened example to government and management. Neither it nor they have anything to fear from the transition, and they have all the world to gain.

I am conscious of a responsibility and a sense of occasion on writing this particular column. To be asked to write the last word, no less, of this anniversary issue, just after my own retirement from the frontline. A great privilege.

And this is what I have decided to say:

I have done the job, and I have my theories about it. But I haven t got the answer. Nor has the College got the answer. Nor has the government got the answer. It is all a great deal more difficult than it appears to be on the surface. The government should join the College, and now me, in offering the people who are still doing this most impossible of jobs (every single one of our patients die in the end, Minister, and they always will) what they richly deserve, what they offer their patients, and what they will gratefully reciprocate. To put it in a single, last word of the half-century:

Respect.