AFTERNOON SESSION

Dr J. M. Henderson, M.D., F.R.C.P., D.P.H. (vice-chairman, The College of General Practitioners) took the chair and opened the afternoon session.

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Dr H. W. Ashworth (*general practitioner, Manchester, Darbishire House, Health Centre, Manchester*): The Art and Science of General Practice—a title such as this might imply that I am an aged retiring professor delivering a farewell address to a gathering of final year medical students. You would be wrong in all these assumptions. In the first place I am not aged—though I might be rapidly ageing through the onerous duties of general practice. Nor am I a professor, but a general practitioner like you all, and I realize that I am speaking to a learned body of men and women, many of whom have had considerably more experience of life than I have; men who by your presence here this afternoon demonstrate your devotion to your calling and your determination to uphold the standard of our profession. Before you get paranoic after this morning's self-criticism session, you will remember what Robert Louis Stevenson wrote:

> There are men and classes of men that stand above the common herd—the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule—he is the flower (such as it is of our civilization; and when that stage of man is done with, and only to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those that practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage so that he brings air and cheer into the sickroom, and often enough, though not so often as he wishes, brings healing.

and if you believe that the status of the general practitioner has gone down in public estimation, note the results of recent opinion polls.

If our thoughts and discussions this afternoon are to have meaning, I feel we should be quite clear about what we are thinking. May I draw your attention to the title once again: " The Art and Science of General Practice ". We are not talking about medicine as a whole, but general practice. In what way does this branch of

medicine differ from the rest? I take as my definition that of John Hunt:

> General practice is that field of medicine in which the doctor accepts the continuing responsibility for providing or arranging the patient's medical care, which includes prevention and treatment of any illness or injury affecting the mind or any part of the body.

It is the continuing care which is important, and overall coverage which characterizes general practice. There is one other feature of our branch of the profession and it is this—that through the family doctor the patient usually makes his first contact with the health service and makes his wants known. Our ability to clarify these demands and our success in satisfying them determine our patient's relief and the general practitioner's personal satisfaction. I believe that much of the present frustration in general practice arises from our failure to achieve these elementary aims. So much for our definition of general practice.

Science is the " systematic knowledge of natural and physical phenomena " or " truth ascertained by observation, experiment and induction ". So the science of general practice is concerned with " collecting by observation and experiment all the facts we can obtain in that branch of medicine concerned with the continuing and overall care of our patients ".

But this is only part of our subject today. We are also asked to think about the art of general practice. The art of general practice has been cynically described today as " the ability to be therapeutically effective in the absence of scientific data ". Whoever ennunciated this dictum spoke better than he knew.

You may have at your finger tips all the scientific knowledge in the world and yet fail to be therapeutically effective in looking after your patient in all the vicissitudes of life. Alternatively, if you do quite simply cure your patient through scientific knowledge alone then you are not practising the art of medicine. And the ironical thing is this, that the more we know about the patient scientifically the less we seem to understand him. At any rate in a recent survey only about 40 per cent of hospital patients were satisfied with their treatment compared with 75 per cent of patients attending general practitioners.

In the latter half of the twentieth century what are the most important scientific facts which affect us in general practice, and how are we to use our art in order to be most therapeutically effective? The scientific advances are the great advances in diagnostic techniques and therapy.

Two events have played an important part in increasing our knowledge of the science of general practice. The first event was the

introduction of the National Health Service which enabled everyone to seek free medical care, and this has produced a mass of information concerning morbidity, of which, prior to the National Health Service, we were ignorant. The second event has been the establishment of the College of General Practitioners, which, by encouraging observation and co-operation, has enabled general practitioners to carry out investigations and record observations in their everyday work and to report their results in the journals. One has only to think of the work of Dr Fry and Dr Hunt. Dare one say it—the modern counterparts of our forbear Mackenzie?

And what data has come to light? We have a mass of statistical information concerning morbidity. We have factual information concerning the amount of medical attention demanded by patients from the womb to the tomb. We even know that in Scotland the doctor gives twice as much attention to his flock as in England. It is said that the cellars of the Ministry of Health are bulging with factual information. What we want is someone to interpret its significance.

Now it is clearly important to know all this. How otherwise can responsible authority organize an efficient health service for the community? We did not have these facts before 1948, and you are all suffering now as a result. The art of general practice *vis-a-vis* medical demand today lies in organizing our professional lives to deal with the demands, and to go on living.

The art of the family doctor lies in assessing the patient's needs, picking out what is potentially important and what is unimportant and arranging the appropriate care where necessary. No one can teach you how to do this quickly and efficiently—it is an art which you acquire—or fail to acquire—and if you fail you will go under.

May I remind you that every patient in consultation presents three features for your consideration—his physical complaint; his social environment; his emotional state. Science will help you considerably with the first, but the other two aspects of the patient's problem will need your art to assess. You know as well as I that it has been said that the patient's complaint is often only a visiting card whereby he can respectably open the door to your surgery.

General practice in 1964 presents us with a new ability to practice pre-symptomatic diagnosis. I give as examples the detection of cancer of the cervix, of incipient diabetes and latent anaemia. Now science tells us that there are eight diabetics per 1,000 and about the same incidence of pre-malignant cervices in women. Science will tell us of techniques for detecting these, but it does not instruct us how to persuade people to accept a campaign for detection. When I offer a free medical examination to people aged 45 to 55 only 60

per cent accept. When I offer free cervical smears to women between 40 and 50 only 20 per cent accept. How do I persuade the others to come along? I have given away thousands of clinistix and found a few patients with glycosuria—but it is the art of medicine which must tell me how to handle these patients. This is a branch of our art which as yet is relatively undeveloped. Certainly, science does not tell me which patients I should treat and which I should leave alone. Science supplies statistics, art alters attitudes.

Our colleagues tell us that 30 to 50 per cent of our patients are in need of psychological help and that is why they consult us. Am I alone in finding myself unable by reason of my art to help them? Dr Balint and the Tavistock Clinic demonstrate this art to us, but so far I have not got the art of the art. Yet this is an important situation today. I suggest that in the field of mental health above all others the general practitioner needs his scientific knowledge of techniques and drugs available, but he needs his art to use them intelligently. You know as well as I that in your surgery you must pick out here and there among the neurotics the ones which you feel can be helped scientifically—and to the others you lend an ear, sympathetic or otherwise.

I warn you not to be too self-satisfied with the results of your consultations. As general practitioners we are apt to over-estimate our therapeutic affect. In a recent experiment in Israel patients attending the surgery were interviewed before their consultation with the family doctor and again interviewed after the consultation. Forty per cent of those attending the general practitioner thought they had some serious illness, and of these 1 in 10 came away reassured. This result was counterbalanced by the fact that 1 in 10 who thought they had not got a serious illness came away convinced that they had some disastrous malady. So you see the general practitioner had gone through the actions of consultation and had given instructions to his patients, but failed in his primary task of reassurance.

This decade is witnessing the growth of social medicine. It is no longer sufficient for the general practitioner to be a diagnostician and prescriber of drugs—important though that may be. The general practitioner in the 1960s needs to see the patient as a working member of society. The increase in scientific knowledge makes it increasingly likely that your diagnosis will be correct and your therapy effective, but you will need the art of medicine if you are to care for the whole patient, and if you are a worshipper at the feet of the idol of science you will most surely come unstuck. How often does the electrocardiograph let you down when you suspect a patient has had a coronary thrombosis? It is quite obvious that in order to look after the whole man we require the help of our ancillary services,

but so far nobody has taught me the art of getting along with my colleagues, and you will agree that satisfactory human relationships is an art in itself. If as a doctor you are concerned only with how the patient feels you had better be a psychiatrist. If you are interested in how he feels and how he is, your place is in general practice. If you are concerned only with how the patient is and not how he feels, consultant surgery is your metier. If you are concerned only with how the patient was then pathology and the post-mortem room is your domain. If the secret of the art of general practice lies in good human relationships this must apply both up the hierarchical scale and down it. The family doctor must be on more than nodding terms with his consultant colleagues on the one hand; on the other health visitors, district nurses and social workers must feel able to approach and talk to the general practitioner on equal terms. And may I say this—with all the new scientific marvels of communication, the telephone, the electric warning system in hospitals, dictaphones, it seems to become increasingly difficult to ensure that all concerned in the patients' welfare are fully cognizant as to what is taking place.

Many general practitioners are depressed because they have so much paper work. They do not realize that by the use of the pen the family doctor brings to the patient all the resources of the welfare state. Perhaps these resources are not as all-embracing as they should be, and this makes us irritated if we cannot do all that we would. The science of general practice tells us that in future we shall have an increasing proportion of old people and babies to deal with and that these patients require two or three times as much care as the younger and middle-aged groups. Is it really medical care that patients need or are they looking really for other satisfactions? Your duty as a general practitioner is to assess their needs not only medically but socially as well—and your art will lie in getting these old people to accept their true needs and thus be to a greater extent satisfied. And so, you see not only is the science of general practice ever increasing our knowledge, but the art of general practice is changing. A century ago the family doctor was relatively diagnostically impotent and therapeutically sterile. He could do little with his pneumonias or diphtherias except pray by the bedside. Now with all the tools of modern diagnosis and a potent therapeutic armementarium he must be a man of action, but he needs new art to make use of his tools of trade intelligently and efficiently.

Finally a word on prognosis. This has ever been a most difficult art in general practice, and surely another example of the change taking place today. We have all had patients with congestive heart failure on diuretics and digitalis for two decades. Who would have thought 20 years ago that these patients would still be alive? Yes, we must look to our art in prognosis.

And so in general practice as in the rest of the medical field art and science must ever go hand in hand.

May I close with Robert Hutchinson's Litany:

From inability to let well alone,
From too much zeal for what is new, and contempt for what is old,
From putting knowledge before wisdom, science before art, and cleverness before common sense,
From treating patients as cases, and
From making the cure of a disease more grevious than its endurance
Good Lord deliver us.

V

Dr R. F. L. Logan (*director, Medical Care Research Unit, Darbishire House, Manchester*): Continuing the theme and something of the atmosphere of the revivalist meeting: " It is nice to see so many old faces in the congregation here this Sunday ". The faces are old to me, many old friends: thank you for coming. They are also old in terms of years. I note this in my own middle-age. (The first of my sons, entering medicine, has written me off as a ' square '; and rightly so when I look at his textbooks about the genetic code and molecular biology).

It may well be that the College, following its birth and the fruitful period of its early growth and promise has settled back, prematurely and without enjoying an adolescence, into middle-age. But the College has never lacked courage. It has set this theme " The Art and Science " to be tackled as a global problem and in changing societies, while, as a footnote, is appended the " Problems of General Practice ". The speakers from other countries have shown that the problems are international. They cross frontiers of ideology, and so we in Britain, who are traditionally bound to general practice, should find it useful to look wider afield.

Briefly, let us run through what is hitting us as doctors. Coming through the surgery door may be the common cold—and, after all, simple minor illness accounts for 30 per cent of patients that do come through—or it may be a cancer for which medicine can do little. The next patient may be stricken from a stroke and another continues at work whilst being cured of tuberculosis by antibiotics. So with some patients we may be only able to succour as our forbears did back in the last century; while for others, we may cure dramatically as a modern scientist. So it is art and science and the " next