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.

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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

patient, please" may require either the science or the art in this half-baked epoch.

In the situation today when most disease is so-called degenerative, the old dichotomy of prevention and cure has long gone. Disease today is chronic, ambulant, and outside hospital. It is recurrent, often handicapping and life-long—and this includes mental disease. To talk about preventive as opposed to curative medicine for these dominant kinds of diseases is without meaning. We may try to dodge this and talk about 'secondary' prevention and screening, but in practice, by surveillance, we are controlling chronic disease.

These changes in the pattern of sickness happened far too fast for any branch of the profession. Hospitals continue at the tempo of the converted workhouses in which many are doing their job. (And at the cost of the long British waiting list, which other countries do not have.) Public health is trying to move from its traditional victories of the sanitary sciences—it keeps polishing up the brass on its old tenets and wonders what it should be doing in community care today. The family doctor practices his cottage industry from a converted parlour or corner shop and unlike the hospital with its organization for planning and evolution, the machinery for general practitioners is limited to making payments and dealing with complaints. Such syndicalistic anarchy was another symptom of the rapid technical advances in medicine changing the relation of the Profession to the State—but too slowly in a Welfare State.

Thus it is for good reasons that the three branches in Britain are finding it difficult to adjust to this new and changing situation. Indeed, we are right in the middle of it, and right in our middle-age. I would ask, as John Hunt did yesterday, where have all the young men gone? Where are the tigers, where are those in their twenties and thirties? It is to the coming generation of young doctors that we would hope to see the 'new look' in family medicine before it falls out of favour with the general public in Britain as it has done in other developed countries to the loss of both patients and doctors, of both medicine and society.

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Let us look rather briefly at something about the art of general practice. As Dr Ashworth has said, the cellars in many places, including the Ministry and the College, are bulging with masses of data as half-baked and undigested as many of our ideas. But we do know, that a group of 170 keen, obsessional volunteers—wonderful record-keepers—state that contacts with patients vary in a year from two to eight. There is something very intriguing and personal in this wide variation. particularly within the College.

In the doctor-patient relationship, visiting varies from rural high-

land Scotland, quite naturally, from one to one, to the lowlands where it is one home visit for every two or three surgery visits. As you come south into England the home visits decrease but never get beyond about one to six. Whereas, if we go across the Channel to Holland, Denmark or Sweden, we find the figure is as low as one in 20, and in North America home visiting has almost disappeared. Yet we think we are all delivering very much the same kind of medical care. This brings us right up against the operational problem in Britain, that the general practitioner is busy, but the almost static output of medical schools is falling behind the population acceleration. And this gap is only the beginning, because these girls of the ' bulge ' are now starting to breed at 1946-7 rates and this means even more babies in the very era when adults are surviving into old age—the two age groups that demand twice the care of the young and middle-age. So when we talk about the busy general practitioner, we should realise that he is going to be even busier still. Yet something like a quarter of this time is spent as a self-chauffeur in his car on a social visit to the patient's home.

When we also glance at the use of direct access to hospitals facilities for x-ray, pathology, and cardiogram we find that it varies from up in the hundreds, per thousand list a year, down to zero for a quarter of general practitioners whose (para-sensory perception I envy so much because they do not need to use these diagnostic frills at all.)

Can we examine something about the art of how medicine is practiced, why there are these wide individual variations, and can we try to obtain some meaning of them? This is surely a crucial point of general practice today: the general practitioner in Britain is going to be very much busier, for the next decade at least, and patients are going to be expecting more, and we on our side have more to give because medicine today has so much greater power to do good—and greater damage if it is omitted.

How can we cope? Here is a practical problem for both the College and the Ministry. Meeting it will not be by " Doctor's Orders ", booklets. It needs more of a grand debate in and with the public, e.g. discussing " The number of general practitioners is limited. We are already busy. If we do all these visits, many of which clinically are unnecessary, then this is at the price of a rushed examination in the surgery, and not enough time to listen. Early symptoms can be vital but chickenpox is not." The public and the profession have got to get together and examine this mutual problem before it gets worse. Doctor and patient are each captive to tradition—and on the hospital side if patients are kept too long in hospital at £5 per day it is at the price of a waiting list if nothing else!

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Now to turn to the science. When we look at the research that can only be carried on outside hospitals in general practice; it brings us right up to the frontiers of clinical knowledge. Just what is diabetes when one quarter of women past middle age on our lists have ' diabetic ' glucose tolerance curves. And there is the practical point: When do you start treating, and to what, if any, effect? This is where general practice and clinical research are pioneers together. What is happening to the passing epidemic of peptic ulcers that crept up between the Wars, exploded during the Second when one in ten men suffered at some time, and is now apparently declining? What is going on in the decline of cervical cancer with better personal hygiene? For all men deaths from coronary heart disease seems to be flattening out and from doctor's own death certificates it seems to be declining. The majority of these patients are in general practice and not in hospital. Apart from physical diseases, what really is going on in the mental health with most depression met and treated by the family physician? Here in the science of medicine, general practice is right up in the frontline of advancing clinical knowledge.

In handling chronic disease today the family doctor uses both the science and the art but such sickness is life-long, relapsing and recurring and disabling. We as general practitioners have been certifying men as sick for absence from work increasingly year by year for the last ten years. Thanks to modern drugs and incentives in our acquisitive society most patients are quickly back at work. But when a man is off work for more than three months in his early fifties there are high chances that he will never return to work again. We often know this patient only too well. He is hanging around the house without a role, becomes fed up and a nuisance. He has lost his status in society as well as in his own family. This is going on in our own country where we had the best rehabilitation set-up in the world until Canada passed us a year ago. But the disablement resettlement officer (D.R.O.) is as rare in general practice as is the health visitor although he is eager to be phoned at the labour exchange in every village by the general practitioner.

One of the few studies of sickness certification of chronic disease taking the patient increasingly away from work—when it is a human need in a man to have work, to be the wage-earner and to have status in the home—was dealt with by Dr Ashworth. He showed that by calling in the D.R.O. to help rehabilitate or retrain the disabled that the general practitioner can do a lot of good medicine because work is therapy.

This, of course, brings us to the aged. Here we all pay our lip service, but it is worth thinking of the Chief Medical Officer's

remarks that the care of the aged is essentially care in the family, by the general practitioner with the supports of the community. But in Britain we make it this artefact of geriatrics as a hospital specialty, because, on the one hand public health was slow to adapt to the needs of the community, and general practice, on the other, had not been trained to cope with the difficulties. So our surplus beds in hospitals are filled and geriatrics as a specialty was created. Apart from Anderson's studies in Edinburgh, we have very little light on this large chunk of the general practitioner's load of work.

Finally to teaching. It is not without reason that tertiary education feels that teaching and research must go together. Because what changing subject like modern medicine can you teach if you do not know at first hand how and why it is changing? This may not be popular in the College. But how do you teach in the sense of a dynamic learning process that will carry on into middle age? I do not mean preceptor; I do not mean the uncritical observation from farming out to popular general practitioners. I mean tertiary at university, professional level. The tools of this are much more than observation. The undergraduates needs to handle patients themselves in general practice and some over some months. It means essays being written and cases being critically presented. None of these methods are new at all to medicine but the teachers of the future will first need to learn their new tasks.

Dealing with the art and science of medicine in this explosion of new knowledge Pickering says, " Half the facts we teach the students today will be out of date ten years hence, the trouble is we don't know which half "—and it will be ten years hence that is the important period. Our objective is to carry increasing professional competence—as in the professions of architecture, or law—into the thirties and have enough momentum for that to continue into the forties or even fifties but after sixty please leave us alone. In contrast to training specialists to be increasingly expert technically, to develop and increase competence in general practice is one of the toughest undergraduate, graduate and postgraduate challenges for any medical school.

Today, contrasted with ten years ago, we seem to know so much about general practice, to have explored so many of its problems. And yet the theme has kept recurring today: how little do we understand of what lies behind so many of these things. This, of course, makes it all the more difficult, particularly when one is dealing with this particular personal relationship of the one doctor to the family. It makes us realise that although we like to think we are scientific in many ways, in others we are still at the poet Housman's level of " liar, physician, hypocrite and friend ". Medicine is a way of life.