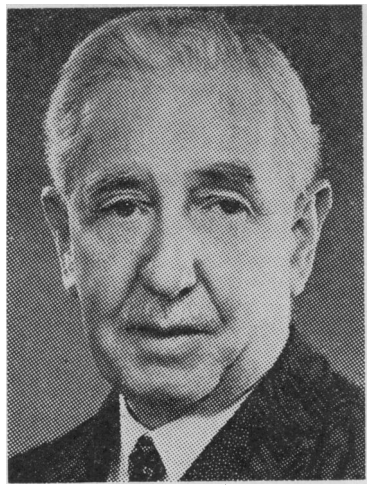

DR. IAN D. GRANT

The Third James Mackenzie Lecture

OUR HERITAGE AND OUR FUTURE

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I am very conscious of the great honour the Council of the College of General Practitioners has conferred upon me when they invited me to deliver the James Mackenzie Lecture, and I am even more conscious of my own limitations and shortcomings, adequately to follow in the footsteps of my two predecessors, who delighted you with such thought-provoking and brilliant contributions on previous occasions.

Many of us are apt to forget the great heritage to which we have fallen heir and to think mainly of the present with its many difficulties and problems and perhaps sometimes to look into the future and ponder about what it holds for those of us who practise the Healing Art. Physicians have served mankind since the world began and, throughout the ages, have exerted an influence on their life and times far beyond that of the ordinary citizen. Our profession has, I think justifiably, always been held in high esteem, and in the book of Ecclesiasticus it is written—" Honour a physician

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with the honour due unto him, for the uses which ye may have of him: for the Lord hath created him." The earliest instructions to the physician are found in a manuscript attributed to Hammurabi, a king of Babylon in the year 2000 B.C., where we find that a very high degree of competence is required of one who would practise as a surgeon—" If a doctor shall treat a man and shall open an abscess with a bronze knife and shall preserve the patient, he shall receive 10 shekels of silver, but if a doctor shall open an abscess with a bronze knife and shall kill the patient his right hand shall be cut off." In the year 500 B.C. we read in the Egyptian book of Thoth—" No blame shall be incurred by the physician if the patient dies provided that the physician adheres to the teaching of this book but if he departs from the proven methods of treatment and the case ends fatally his own life shall be forfeit"—a dictum which gave little encouragement to the research worker in the land of the Pharaohs.

Hippocrates is regarded by us as the Father of Medicine and he lived and practised in the island of Cos about the year 460 B.C. He wrote voluminously and the characteristic that stands out most clearly in his writings is his inherent honesty and his abhorrence of sham and trickery. He records, unlike his contemporaries, his failures and his successes with equal impartiality. Many statues of Hippocrates are in existence, and all of them depict a gracious and dignified figure and we can well imagine him as an inspiring teacher and a skilled and sympathetic physician. The Hippocratic oath is still regarded as the ethical code to which all members of our profession subscribe, and, in these days, when there is a tendency in many places to regard doctors as mere craftsmen, in essence not very different from other technicians, it is well to recall the noble code enjoined on his disciples by Hippocrates—" I will use all ways of medical treatment that shall be for the advantage of the sufferers according to my power and judgment and will protect them from injury and injustice. Purely and holily I will keep guard over my life and my art." The genius of Hippocrates is not merely a matter of historic interest, he taught us that our full attention must be focused on the patient as an individual. " We cannot be too frequently reminded that our natures are the physicians of our diseases and that the physician must study the patient and his environment." That was the message of Hippocrates 2,400 years ago and is it not still the message for us to-day when the tendency is to remove the patient from his environment and translate him to the mechanised medicine of the hospital ward ?

After Hippocrates, the most dominant figure in medicine was Galen, who practised his art in A.D. 200. He was a forceful and dogmatic personality who, though not a Roman, was summoned

to Rome by the Emperor Marcus Aurelius who said, " We have but one great physician, Galen." In such high esteem was the physician held in those days that he was exempted from combatant service and from paying taxes. Galen taught that all disease was attributable to variations of the four humours; blood, phlegm, yellow bile and black bile. So long as these humours remained in static equilibrium, the patient remained in good health, but any disturbance of their relative predominance betokened the onset of disease. Galen propounded these views with such conviction and authority that they were accepted and taught unquestioned for nearly 1,400 years. Galen believed that the blood ebbed and flowed through a porous septum in the heart, and it was not until 1628, when Harvey demonstrated beyond all doubt the true nature of the circulation of the blood, that the physicians began to doubt the accuracy of Galen's teaching. Harvey brought a new outlook to medicine; clinical research, which had been dormant for centuries, was re-established by Sydenham—" Go to the bedside—there alone can you learn disease "; by John Hunter—"Why think? Why not try the experiment ? "; by Smellie—the father of obstetrics; by Jenner, a shy country physician; by Pasteur; by Lister who performed his first operation under antiseptic conditions in 1865; by Simpson, the genius who made anaesthesia possible in the face of opposition from his colleagues and from the clergy who said that: " It would rob God of the deep and earnest cries of women in Travail ". Antisepsis was quickly superseded by asepsis and, by the end of the nineteenth century, the era of the specialist both in medicine and in surgery had arrived. Up to that time, all the advances in medicine had been achieved by men who had been predominantly engaged in general practice, but, with the advent of the twentieth century, medical science attracted numerous brilliant young research workers, and each decade gave to the physicians and surgeons more powerful weapons with which to combat and, indeed, often to prevent disease and ill health. At that time, nearly all advances and discoveries in medicine were made by those engaged in hospital work. The general practitioner had become the Cinderella of the profession, and it was not until Mackenzie startled the whole world with his work on the irregularities of the pulse and revolutionised the whole treatment of heart disease, that the giants of Harley Street realised that worth while work and research could be successfully undertaken by one engaged in general practice. All of us are familiar with the legend that has grown round Mackenzie, but many of us may not be so cognizant of the difficulties which he encountered and the prejudices he overcame. We may, therefore, find it profitable to reflect for a little on the life and work of one who so well merited the title of " the beloved physician ".

James Mackenzie

James Mackenzie—the son of a Scottish farmer—was born on 12th April, 1853, in Scone, near the ancient abbey where, from remotest antiquity, the Kings and Queens of Scotland were crowned. There was little in his early life to foreshadow the greatness to which he attained or the impact he would make on the medical thought of his own and future generations. He had no overwhelming desire even to become a doctor—indeed his first love was to engage in pharmacy, and it was not until he was 21 years of age that he went to Edinburgh—then the most famous medical school in Scotland—to begin the study of medicine. His undergraduate career—like his schooldays—was not especially distinguished although, in his final year, he surprised and delighted both himself and his friends by gaining three medals. All through his university career he protested that he could never understand why teachers should set so great a store on the exercise of memory and the ability to reproduce other people's phrases, teaching and opinions, and so small a store on the exercise of reason, personal observation and deduction. When he himself was acclaimed as a great teacher he spoke thus to a session of the Royal College of Physicians—" The outcome of the teaching of to-day is to hail the student with superior powers of memorising as the brilliant student and the one with the great future. In the absence of any knowledge acquired from his own observations, he is forced to teach that which he was himself taught, and as he cannot distinguish between Truth and Superstition he hands both on to his students ". To some extent that might still be a criticism of present-day teaching. Mackenzie graduated in 1878 and, after a term as house physician in Edinburgh Royal Infirmary, he wrote to a friend, " I felt a longing to devote myself to some of the branches of medicine concerned in research, but my very moderate attainments precluded me from obtaining a university post and I recognised that I was only suited for what is considered to be the lowest sphere in the medical profession ". How little did he then realise that, by his precept and example, he would prove that general practice is the one place in which the early signs of disease can be studied. The stone which the builders rejected through the genius of Mackenzie, had become the head of the corner. His introduction to general practice could hardly have been more arduous. He went as a locum to a colliery practice in Durham. At that time the standards of practice in the industrial area were low. The club system was the recognised method of payment for medical services where, for a pittance of *6d.* per week, the doctor contracted to give medical care and all necessary drugs to the wage-earner and his family. The status of the doctor was

poor. Professional ethics were deplorable, and there was keen and often unscrupulous competition even for these ill-paid posts.

The local club secretaries—almost invariably coarse and ill-educated men—exercised a nearly tyrannical control over the doctors. The whole system was degrading and depressing. Mackenzie records that the most popular remedy in the dispensary was a concoction of burnt sugar and ginger. It gripped. It had a fine colour and enjoyed a high reputation as a specific for all ailments of the digestive tract. In 1879 this tall, kindly young Scot came as an assistant to Dr. William Briggs in Burnley—a drab, grey town where the click-clack of clogs resounded all day on the cobbles and where for the next 25 years Mackenzie lived and worked and played with these hard-headed but warm-hearted Northern people. For this young doctor was no ascetic. He was a good golfer, a skilled billiards player and no mean exponent of the art of boxing: withal he was endowed with that kindly courtesy to old and young which is so necessary a pre-requisite for a successful family doctor.

About 1884 Mackenzie began to formulate to himself some of the problems and difficulties he was encountering in practice and for which he felt there must be some solution. He wanted primarily to understand the causation and the mechanism of symptoms and their relationship to prognosis. And just then came to him one of those tragedies which happen to most of us at some time in our career. A young patient died completely unexpectedly. Mackenzie was seated at the bedside of a young primipara. Her labour seemed to be progressing normally. He spoke words of comfort and encouragement to her as she moaned softly in her hour of travail. Suddenly her pulse flickered and was gone. Before his eyes she died of sudden cardiac failure and, that night, as he paced the floor of his consulting room, his confidence sadly shattered by the tragedy, he kept asking himself—" Would she have died had I known more about heart affections? " There and then the decision was taken. He determined to give close study to the symptomatolgy of heart disease with special concern for the pregnant woman. He found that it was only after disease had made considerable ravages in the body that an accurate diagnosis could be pronounced, and that with early symptoms of ill-health—often with no actual physical signs presenting—the only way to ascertain what a symptom betokened was to wait and watch that patient over a period of years. There was no short cut to this knowledge. The text books of his day gave him no satisfactory answers, and so this courageous, busy practitioner evolved his own methods. At first his recording instruments were clumsy and primitive. His colleagues and

friends laughed good-naturedly at him as "the doctor with the drums and smoked paper", but he steadfastly pursued his way and, gradually, without any help from the current medical literature, he came to realise that the accepted treatment of heart disease was wrong and that many people who should be leading full and active lives were being condemned to invalidism and inactivity.

In 1902 he published his first book, *The Study of the Pulse*. Writing of the irregularities of the pulse he says, "It took me 20 years of patient observation of these irregularities in health and disease before I could prognosticate accurately". This volume brought him fame and recognition in Germany and America, but London was, at first, just faintly amused. Was he not merely a general practitioner, and what could he know that was new about the action of the heart and the treatment and prognosis of its many disorders? But although the prophet was without honour in his own country, the savants of other lands were impressed. He was invited to America, to Canada and to the Continent, and everywhere he was hailed as a seer and a great physician. Burnley became a place of pilgrimage for distinguished foreign scientists who wanted to see the man and to discuss with him his problems, his investigations and his deductions. But the giants of Harley Street did not come. How could a busy general practitioner with his limited knowledge, his lack of hospital and laboratory facilities, and, indeed, one who still practised in the homes of the people—how could such a man overthrow all the accepted teaching about heart disease? But the challenge was met, and, at the age of 54, after 25 years of patient investigation, Mackenzie decided that he would go to London and endeavour to impose his views on a doubting and reluctant profession. His first year was fraught with difficulties. He tells us about his recompence. In that year he earned only £114, but in 1908 he published his book *Diseases of the Heart*, a book which exercised an influence over current thought almost without parallel in medical history. On the cardiologists of London the impact was devastating. No longer could they ignore this North Country general practitioner. Here was a completely new exposition of the symptomatology and prognosis of disorders of the heart, and the course of each disease was illustrated with graphic records, recorded at the bedside, each of which was analysed with meticulous accuracy and studied over a long period of years. The evidence in support of his conclusions was overwhelming and irrefutable. Let us at once admit that London capitulated. The new teacher was loaded with honours. He was made a fellow of the Royal College of Physicians. He was invited to become the head of a newly created heart department at the London Hospital where all the resources

of that world-famous institution were placed unreservedly at his disposal. The wheel had indeed turned full circle and the obscure country practitioner of yesterday was hailed as the leading consultant of to-day.

Mackenzie gratefully and gladly accepted the honours that were conferred upon him, but his colleagues had not yet accepted his fundamental principles. They honoured the tracings, the polygraph—the forerunner of the electrocardiograph—more than the patient clinician, the man who waited to see. They were shocked by some of his pronouncements, which indicated that Harley Street must adopt a new outlook as well as a new scientific instrument. " It is not second sight which I possess but only sight. My eyes were opened because I had real need to use them. No instrument or polygraph can replace the finger, the experience and the reasoning powers of the doctor himself." Always he stressed the importance of the family doctor. " The early stages of disease are as a rule insidious and are indicated mainly by subjective sensations. The patient, conscious that something is amiss with him, does not as a rule seek help from the hospital physician but rather from his family doctor. The bulk of patients in the early stage of disease are never seen by those who are systematically engaged in the investigation of these diseases."

A distinguished American physician, having spent some time at the Mackenzie school, finally asked, " What line of research would you advise me to pursue when I return home ?" and the great man replied, " I would advise you to go into general practice and stay there for ten years because it is only in general practice that a doctor can learn to foresee danger to his patient and how to take steps to prevent it."

In due course the new principles of cardiology became established, but Mackenzie himself still insisted that research must originate in general practice. To one of his most brilliant disciples he said, sorrowfully, one day, " If only you had had even five years in an industrial practice." Hear him:

> Common sense would say that where signs of dicease are most difficult to make out, there the most experienced physician should be employed, but in no teaching hospital is this ever done. Here in the Out-patient Department is placed the youngest member of the staff, often lacking in experience and ignorant of the meaning of subjective signs. If there are no obvious physical signs the patient is sent away perhaps with a bottle of physic but not until physical signs are apparent does he come under the care of the senior physician. On the other hand, in the wards where the case has advanced so far as to produce physical signs—mostly easy of recognition—we have skilled physician and all the assistance of the Research Laboratory.

So wrote Mackenzie in the early years of this century, and

although his criticisms may have been severe and scathing, is there not still much truth in his plea that the trained physician should be in the outpatient department where his skill and experience may detect disease in its earliest phases?

And so, in 1918, the man who was hailed as the greatest cardiologist of all time, the creator and the inspiration of the Mackenzie School, which attracted to its precincts the most brilliant of the young physicians, decided that he would leave his consulting rooms in Harley Street and return to general practice. From these young physicians Mackenzie was separated by an almost unbridgeable gulf. They belonged, in their hearts, to scientific medicine. They worshipped the gods of the machine and of the laboratory. They had never practised medicine in the homes of the people where they would be partners in the hopes and the fears, the difficulties and the triumphs of their patients, where they would know the re-actions of the child to illness from his earliest years, and learn to foretell how he would re-act to the diseases that befell him in later years. They had tried to appreciate the view-point of Mackenzie but they had failed and there is much of pathos in the spectacle of the old physician—the beloved physician who had for a time become the high priest of the neocardiologists—leaving his disciples and returning to the field of work in which, he felt, lay his true vocation. And so to St. Andrews, where he founded the Mackenzie Institute, in which he hoped, with the help of local general practitioners, to study the earliest symptoms of disease. He appealed to the doctors of this cold, east-coast town simply as man to man and he won their wholehearted co-operation and support. He became consulting physician to the small cottage hospital which was staffed by the general practitioners of the town. And so for six years he inspired the family doctors around him in St. Andrews and indeed in all Scotland, for many came to visit the Institute and to seek inspiration and guidance from the founder. One of my colleagues, when a young assistant physician, was sent by his chief with some slides of arterio-sclerosis to ask the opinion of Mackenzie about them. He tells me that Mackenzie just glanced at them and said," I know nothing about them, laddie, but come with me and I shall show you something I do know about." He took him to his museum, where he demonstrated the heart of a patient whom he had attended for 20 years, and showed him where the disease had originated and how it had progressed. To this day my colleague regards that hour as the most memorable of his whole medical life. At his weekly clinics, Mackenzie would demonstrate cases, oftentimes stressing the presence of a symptom which his colleagues had either overlooked or

misunderstood, and always he urged the need for constant observation and untiring watchfulness. He has said :

> When I see the modern cardiologist getting his assistant to take an X-ray photo of the heart, an electro-cardiograph and even a blood pressure reading and then behold him sitting down to study these reports, I am truly amazed. I never could have realised that the practice of medicine would become so futile and ineffective. I must warn you against any immediate expectation of achieving the chief aim of medicine—the prevention and cure of disease. A long and weary road must be travelled and our immediate objective, after training ourselves in the detection of symptoms, is to find out the nature of these symptoms and, by watching patients over a period of years, to see what happens. It may be that, in this way, we may detect the causes and factors that favour the onset of disease.

In the early days of 1921, he was compelled to give up active work, and by a sad coincidence, he who had done so much to elucidate the diseases of the heart, was himself stricken by one of the most painful and hopeless of cardiac maladies. In the autumn he returned to London where, despite recurring attacks of pain, he completed the proofs of his last book—a review of the work of his cherished Institute and the new edition of *Diseases of the Heart*. The figure of Death, so long defied, drew close to his side. There was one last seizure, and then a period of peaceful sleep. On the night of 25th January, 1925, the beloved physician went out quietly and serenely to his eternal rest.

What of the Institute which he founded ? Like so many great men he had inspired no true successor. There was a gradual waning of enthusiasm after his death. The impact of World War II scattered what he had regarded as a static population and made the keeping of accurate records almost impossible. To gather up the broken threads was deemed impracticable and the Institute has been closed down. The building is still there, and I sometimes wonder whether we of the College might not one day find ways and means of continuing Mackenzie's work and fulfilling his dream.

After Mackenzie

In the next two decades, discovery followed discovery with almost breath-taking rapidity. Insulin has enabled diabetics to lead a full and useful life. Liver extract has vanquished pernicious anaemia. Chemotherapy holds within bounds the dangers of infectious disease and the antibiotics enable us to triumph over almost all diseases of bacterial origin. We have indeed succeeded to a great heritage. We are living in the Golden Age of Medicine. We have to-day opportunities to practise the science of medicine such as our predecessors never obtained. The general practitioner has never had so many effective weapons in his armamentarium against disease. Surgery has become almost limitless in the marvels which can be

performed. Operations on the brain, the lungs, the heart are commonplace, while the scope of abdominal surgery gives hope to the hopeless. The deficiency diseases, chlorosis, rickets, scurvy are seldom seen and tuberculosis is fast coming under control. With all these advantages, the lot of the general practitioner should be immeasurably improved, but is it? We are confronted with the psychoneuroses, the schizophrenias, the hysterias, the anxiety states, and the so-called stress diseases. Never were the people of Britain so disease conscious, so drug conscious, and so hospital conscious. In the creation of the Welfare State we have lived through a bloodless revolution. We have completely changed the character and the outlook of our people. We have had a great levelling up of things material but little improvement in the responsibilities which the up-grading should provide. Our Scottish poet Robert Burns sang of the desire to:

> . . . gather gear by ev'ry wile
> That's justified by honour;
> Not for to hide it in a hedge,
> Nor for a train attendant;
> But for the glorious privilege
> Of being independent.

How many of our patients to-day wish to be independent? Do they not rather expect the State to guard them always against " the slings and arrows of outrageous fortune? " With the inception of the National Health Service we have had a medical revolution, whereby every citizen is entitled to full medical care without any direct payment to his doctor or to the hospital. The citizen is now very conscious of the rights which he can demand, but he oft times forgets the duty which he owes to his doctor. The old order has changed and now the general practitioner is bound to his patient by the iron fetters of a legal contract enforceable day and night at the whim of the patient. Formerly the bond that united them was the golden thread of mutual esteem and confidence and the obligation to render service was enforceable only by the conscience of the doctor. This has inevitably led to a change in the doctor-patient relationship not, perhaps, in a better direction.

We all realise that the National Health Service is a magnificent and humanitarian conception and none of us would wish to see it fail, but that sense of goodwill need not blind us to its many defects. The inception of the service was unfortunate. It was introduced as a political measure and was enforced upon an unwilling profession by a Minister who made it quite clear that he regarded professional people simply as workers with special skills ; more elaborate, perhaps, but not so very different in kind from the skills of other workers. Indeed in Soviet Russia to-day the general practitioner working in polyclinics finds himself on the same social level

as the woodworker or the motor mechanic. How different from Adam Smith who wrote two centuries ago, " We entrust ourselves and our health to the Physicians. Such confidence could not safely be reposed in people of mean or low conviction and their reward should be such as gives them that rank in society which so important a trust requires."

It is not my intention to comment on the conditions of service or remuneration which we are enjoying in the National Health Service to-day but I do state unequivocably that the success or failure of the Service rests fairly and squarely on the shoulders of the Government. The State—not the doctors—introduced the scheme, and it is the duty of the State to ensure that the people of Britain enjoy a standard of medical care as satisfactory as is provided in other civilised lands. The doctors, to their eternal credit, though they accepted service with grave misgivings, have given of their best to make the service a success. Their wives too have sacrificed much of their social life and scanty leisure in an effort to maintain practice communications, very often without any domestic or professional help, and to them the people of this country and the politicians owe a debt of gratitude that can never be repaid. Without their aid the National Health Service must inevitably have foundered before it was properly launched.

That all is not well with British medicine is evident from the many surveys that have taken place, from the articles that have been published, and from the letters written to medical journals. There is amongst many, both in general practice and in the consultant ranks, and more particularly in the younger age group amongst whom the fires of enthusiasm should be burning brightly, a feeling of frustration, disappointment, unhappiness, and even despondency. Whether the particular type of nationalised medicine under which we work is the best for our Welfare State, whether it will maintain and enhance our scientific reputation or whether in its present form it will be to the ultimate benefit of the patient only time can show, but it is significant that few of our colleagues either in our own Dominions or in America would accept the conditions under which we work to-day. Particularly do they dislike the divorcement of the general practitioner from hospital, the political appeal to the cupidity of the public, and the capitation method of payment. What then should we seek to attain in the foreseeable future ? Our first objective should be unity in our own profession. The tri-partite division into consultants, public health medical officers and general practitioners, all under separate administrations, is an artificial segregation of the profession which can never work smoothly and with maximum efficiency. There should be no real

demarcation between these three sections. We are all doctors with one common aim—to provide for the people of this country the best medical service within our means. In this objective we are all equal partners and it is my firm conviction that the good general practitioner is of equal value to the community as the good specialist. The divorcement between general practitioners and hospitals should be ended, and a limited number of keen and enthusiastic practitioners should once again become members, and full members of the hospital team. Clinical clerkships which carry no responsibility are of some value, but they are not enough. It should be possible for the keen young practitioner to pursue for some years the specialty in which he is interested and, if he can obtain his higher qualifications, the fact that he has been part-time in general practice should be an advantage rather than a deterrent to his appointment to consultant rank.

In pre-National Health Service days, in the provinces, many of our best consultants graduated from the field of general practice. Registrars should be encouraged to undertake part-time work in general practice with selected and knowledgeable practitioners. This two-way traffic will provide that personal contact between practitioners and consultants so necessary if each is to understand and appreciate the problems and difficulties of the other. It would also mitigate the difficulties encountered by those registrars who fail to obtain consultant rank and, as a second choice, wish to enter general practice. A scheme of this nature has already been agreed in principle in Scotland and the experiment when put into action will be watched with keen interest.

Is it possible to define in this socialised and nationalised era just what we mean by general practice? Platitudes such as the "backbone of the profession", the "front line of defence" may flatter but mean little. First and foremost we are family doctors and I would suggest that in the practice of medicine there must always be someone who can still take the broad view and the long view—someone who will see the patient as a whole and over a long period of years, who knows the common illnesses intimately and who knows when the rarer ones should be considered, so that he can then summon to his aid one whose interests lie among these rarities. Even in this age, the family doctor cannot be by-passed. His place in our medical world is still supremely important. He must maintain a balanced judgment and use his own common sense. He must know his patients not as interesting scientific entities but as human beings, with their backgrounds, their families, their jobs, their virtues and their vices. This is the man who can truly follow in the footsteps of Mackenzie, but for him the next decade will be a

testing time and will determine whether he is to remain, as he has been through all the ages, a practitioner of the art, as well as of the science of medicine, or whether he is to be downgraded as a disposal agent to the nearest hospital. Against such a calamity our College must be constantly on guard and vigilant. We must evolve some method by which the general practitioner will accept more and not less responsibility. We must encourage him to treat more illnesses in the home, and to undertake, as he so often did, even within our memory, simple diagnostic procedures and minor surgery. The public must realise that hospitalization is only for serious illness and that, in their general practitioner, they have a doctor who can deal with most illnesses just as skilfully as the " professor " in the hospital ward. Much of the modern demand for hospitalization lies at the door of the politicians, who instilled into the minds of the people that they were entitled to enter hospitals as a right, whenever they wished to demand it.

To enable the general practitioner to give this fuller service will mean an increase in the number of home helps and district nurses and may also involve a reduction in the size of lists with a commensurate increase in the fees payable. The saving in specialist services and hospital beds, and the increased efficiency of the practitioners will more than offset these increased costs.

There must be adequate facilities for postgraduate courses. The average general practitioner has little leisure, but recreation and rest are as necessary for the doctor as for any other member of the community if he is to maintain efficiency. How often must he say, with Davies,

> What is this life if, full of care,
> We have no time to stand and stare,
>
> . . . .
>
> No time to turn at Beauty's glance,
> And watch her feet, how they can dance,
>
> No time to wait till her mouth can,
> Enrich that smile her eyes began.
>
> A poor life this if, full of care,
> We have no time to stand and stare.

How difficult to find time even for recreation and reading ! Yet with the advances in medical knowledge in diagnosis and treatment every year, to remain efficient a doctor must undertake postgraduate work at regular intervals. There must be no financial sacrifice incurred by the practitioner who takes a postgraduate course. A course for a month at a university city every fifth year might be envisaged. All fees, adequate subsistence and the full provision of a locum should be the responsibility of the state for those who work in the National Health Service. These courses should be

arranged by the deans after consultation with representatives of the practitioners and they should embrace all that is new in those diseases which are commonly met with in general practice. The student should also be taught how to recognise the earliest symptoms in the more uncommon diseases, in order that he can make an early diagnosis and refer the case to the appropriate specialist, before the disease is too far advanced. There might well be occasional social and cultural meetings, more particularly in the evenings, when pupil and teacher could meet on common ground. Everything possible should be done to make the postgraduate course memorable in the life of the practitioner. He should return to his practice with new knowledge, new friendship and a feeling of recreation.

Research in General Practice

Any lecture which seeks to commemorate Sir James Mackenzie must take cognizance of research. Perhaps the most outstanding achievement of our College has been the contribution made to research by general practitioners in the past three years. Some hundreds of doctors are enrolled in the research register of our College, and have been stimulated to observe, accurately and carefully, the signs and symptoms of the diseases in which they are particularly interested.

It is a sobering thought that we can give a complete and definite diagnosis only to about 30 per cent. of the cases which come to us for treatment. The others are only labelled with the name of their most prominent symptoms—neuralgia, headache, anaemia, constipation, dyspepsia, and, if the symptom clears up with some simple medicament, we pursue the investigations no further.

The world is too much with us and we say that we have no time, but for the lack of time we may occasionally fail to diagnose the early cerebral tumour or insidious carcinoma. Too often, the word Research conjures up in our minds intricate apparatus, spacious laboratories and a highly trained technical staff. What the word should mean for us is a spirit of inquiry, an effort to create a climate of discovery, a refusal to accept and to subscribe to current beliefs and teaching just because some one had postulated an hypothesis 20 or 30 years ago. As general practitioners, our concern is with clinical research. The beginning and the end of many diseases, treated for a time in hospital, are seen only by us. Only the general practitioner can properly evaluate the treatment given in hospital. The surgeon performs a brilliant and heroic operation from which the patient recovers sufficiently to return home, but only the general practitioner knows to what extent that life has been crippled or

renewed and whether the "successful" operation has in fact been successful. Many illnesses which never require admission to hospital cause considerable incapacity. The psychogenic disorders, the anxiety neuroses so often produced by the whirl and turmoil of modern life demand investigation by the general practitioner, but lack of time may preclude the taking of a detailed history and the patient may sometimes be sent away merely with a placebo for the nerves. How Mackenzie would condemn such a travesty of treatment and how he would insist that we ascertain and endeavour to correct the underlying cause for these functional illnesses.

The capacity for work of the convalescent case of tuberculosis, of the epileptic, of the diabetic, can best be estimated by the general practitioner, who alone has the opportunity of watching the patient in his home environment over a prolonged period.

An opportunity for simple but invaluable research work of this nature is open to everyone of us. To those who complain, and there are many, of the lack of interest in the mass of trivialities that intrude upon the average consulting hour I would suggest that they develop a special interest in one subject, that they keep careful records of each case falling within that category, and they will be surprised how alertness will increase and clinical acumen will be sharpened. Lack of secretarial help and lack of leisure constitute real difficulties, but the satisfaction of finding some clue to the early detection of the disease in which we are interested, of searching for new evidence, of evaluating symptoms, of tentatively fitting a diagnosis—all this will give an uplift to our ego that far transcends the labour we expend.

The Health Service should be above Party Politics

We must strive to remove the Health Service from the sphere of party politics. All parties should, in association with the medical profession, seek agreement on the best methods of maintaining and improving the health of the nation. It is paradoxical that each year since its inception more money is poured out on the Health Service, and each year more money is expended in sickness benefit, and each year more working hours are lost through illness.

In New Zealand, after 15 years of strife and bitterness, both political parties have come to an agreed solution of their differences and have joined with representatives of the medical profession to provide for the people of that great Dominion the best possible service for all sections of the community. In Canada, the politicians and the Canadian Medical Association are exploring the possibility of some form of compulsory health insurance, but our colleagues there draw a very clear distinction between nationalised

medicine and health insurance—the former being, in their view, a regimentation of the medical services by the state whereas health insurance means a pooling of financial resources by the prepayment of premiums whereby illness can be budgetted for in advance. They demand complete freedom of choice between doctor and patient, remuneration on a fee-for-service basis, and they insist that any health service must be administered by an independent and non-political commission, representing those providing and those receiving the services. With these principles the politicians of Canada are mainly in agreement. So long as the health of the nation is used as a vote-catching instrument by the politicians, so long we, as doctors, must feel that we are mere pawns in the game of political chess. We may well wonder whether some day even our professional freedom may be undermined. To prevent such a catastrophe, it is essential that private practice be maintained not as a rival to the National Health Service, but as a friendly competitor with it. The moment the state organises and employs all the members of a profession, we can no longer regard it as a profession. We can only speak of a body of expert officials who might or might not be able to maintain their high standard of ethical conduct. These standards will depend on the state of society—we have seen how low they could fall in Nazi Germany. Any freedom they enjoyed would be on sufferance from those above them who wielded the power. With the ever-increasing domination of the state over our day-to-day living it may well be asked, " Will our traditional professional freedom be maintained after a few decades ? " It is thus essential that some leavening of private practice will remain to safeguard our heritage and to keep in being a last citadel of freedom to which all can at need turn for safety and self-respect.

The tendency of the state in all nationalised industries has been to depreciate quality when the services are overwhelmed by the sheer quantity of demand. At present we have an adequate—perhaps over-adequate—supply of doctors but already there is evidence that the new system is tending to attract recruits with a different background. In one Scottish university, only five per cent. of intending students came from medical families, and, when these students graduate, many of them seem to regard the practice of medicine more as a profession which enjoys a reasonable measure of financial reward rather than as a vocation.

Collins, whose report on British medical practice in the initial years of the Health Service was considered rather damnatory, has stated, " The good general practitioner enjoys to-day more prestige and wields more power than any other citizen unless it be the judge

on his bench. The powers of business executives are petty compared with the power of the doctor to influence the physical, psychological and economic destiny of other people." Surely we should strive to justify that high encomium and to maintain that standard of public service.

In the Old Testament we read that Gideon gathered an army of 32,000 men to do battle against the Midianites.

> And the Lord said unto Gideon, . . . proclaim in the ears of the people, saying, whosoever is fearful and afraid, let him return and depart. . . . And there returned of the people twenty and two thousand. . . . And the Lord said unto Gideon, The people are yet too many. . . . So he brought down the people unto the water; and the Lord said unto Gideon, Everyone that lappeth of the water with his tongue, as a dog lappeth, him shalt thou set by himself. . . . And the number of them that lapped, putting their hand to their mouth, were three hundred men. . . . And the Lord said unto Gideon, By the three hundred men that lapped will I save you, and deliver the Midianites into thine hand . . .

Our College was founded as an act of faith in the future of general practice in Britain. Is it idle fancy, or may it be true to believe that those who are loyal members of our College, who are sincerely fulfilling the obligations which they have undertaken, are the men of Gideon who, in these years of difficulty and frustration, will uphold and perhaps enhance the high tradition of service that we have inherited from our fathers. To them in my dreams I can hear Mackenzie say, " To you, from failing hands, I throw the Torch, be yours to hold it high ".

The use of a General Practitioner's time

by D. L. CROMBIE and K. W. CROSS
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During a year Dr. Crombie has kept records of the actual time spent by him in contact with patients, in travelling between patients, and in administration.

His practice is a suburban one on the fringe of a large city. The registered patients numbered 6,565 but it is estimated that the 6,628 were at risk to two partners: it is assumed that Dr. Crombie was on call for half of these. The age distribution, except for a rather large number of women aged over 65, was similar to that of the population of Birmingham and of England and Wales. There was a high proportion of " black-coated " workers and a relative absence of manual workers.

The time spent on administration was found to be five hours per week, and the travelling time between patients 52 minutes. In all months, excluding February and March, less than 30 hours per week were spent in actual contact with patients and in travelling between them. One interesting and—to many—unexpected finding was that the number of spells of illness per male patient increased in old age, whereas female rates showed little change or declined. Infective and inflammatory lesion of the respiratory system, and the ear, nose and throat accounted for more than one-fifth, and infective and inflammatory diseases of all systems combined, accounted for more than one-third of the total time of the practitioner.

The time spent in relation to the number of episodes of illness was almost identical between the sexes, but, in individual diagnostic groups, there were some interesting differences. The case of a male cardio-vascular illness took half as much time again as in the female. In lesions of the gastro-intestinal system the prevalence of peptic ulcer gave rise to higher male values. The highest mean time spent on female episodes was due to pregnancy.