WITHOUT PREJUDICE

The other day I came across a report on a health centre where an appointments system was based on patients' being seen at five-minute intervals. And every half-hour the general practitioners had a break of five minutes in order to attend to their correspondence. This information was all set out with circumspection and, so it seemed, a note of self-congratulation. I could not discover whether in fact it worked out as the report indicated, whether the patients were satisfied, whether the doctors were practising what is nowadays so often called "good medicine."

I believe that doctors working in groups *should* be able to practise more efficiently than when working in isolation. But the picture of ten doctors practising these five-minute exercises on people feeling poorly enough to traipse all the way to a health centre is more like that of ten battery hens than of ten skilled members of a learned profession.

This is *not* the practice of medicine. There is no point in spending £10,000 to £15,000 to give an undergraduate a long and arduous training if at the end of it all—after a year or two of exciting experience as a houseman—he is to act principally as a human placebo for ill-defined discomforts, the result, often enough, of social malaise and spiritual desolation.

It is certainly not the way to practise preventive medicine. Nor is it possible with this battery-hen technique to discover the beginnings of disease, to spot the early stages of those full-blown diagnostic specimens that are the pride of the teaching hospital and the coveted booty of the examination hall.

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The health centre—it was suggested 46 years ago—would provide the opportunity for the G.P. to conduct research into the early phases of ill-health. And it was in the health centre that the young doctor would receive his real education in general practice. There he would enjoy the fruits of education and research in an atmosphere of co-operation, with aids of every kind at hand to provide the refinements of diagnosis. Medicine a lifelong study was to be the clarion call to the noble and disinterested pursuit of knowledge—yes, for its own sake as well as for the patient. It was a noble vision. It still is. And yet here we have, 46 years later, patients coming in at one door and going out of the other with an attempt at clockwork precision—a five-minute clock—that makes a mockery of the whole idea.

The diagnosis of even advanced disease needs time. How much more time, then, should be needed to detect the early signs of disease! How much more time still should be needed for taking a history that will uncover symptoms of approaching disorder! And how fallacious was the idea that if you lowered all the barriers that kept the public from going to the doctor without let or hindrance then—and perhaps only then—would it be possible to catch disease on the hop! This was, of course, the *one* way to make the early detection of disease well-nigh impossible. Patients arrive in such numbers that five minutes only is the interval between one appointment and the next.

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Dr. John C. Wood's letter in *The Times* of 14 June puts the requirements of the public quite simply and in a way that provides an answer to the question of what to do with the mass of minor complaints. It is abundantly clear, he writes, "that there is a public demand for simple medical advice and treatment on a level which does not require the services of a highly skilled medical practitioner for its satisfaction." He suggests that we should train a new group of ancillaries to be called "Medical Assistants" in half the time now required for training the fully fledged doctor. He foresees the cry that will be raised against dilution of labour. But, as he points out, the midwife and the psychiatric social worker, for example, already bear important responsibilities. The list could be extended to include the whole range of professions engaged in the prevention and treatment of disease and in the rehabilitation of the physically and psychologically disabled.

In his training the medical student is specifically taught how to take a history and how to examine a patient. He is the only one of the "health professions" who is a specialist in the examination of the human body in such a way as to detect departures from a normal that is the average picture formed from countless examinations of healthy persons—examinations repeated in the course of a patient's life. Until all doctors trained as fully—and as expensively—as they are at present have the time and facilities to examine patients with the thoroughness required in their training, their preparation for the practice of medicine is so much waste of time.

For the last 2,000 years or so patients have clamoured for the doctor's attention for any and every complaint, however simple; and for the last 2,000 years or so the trained doctor has been prepared to take on all comers single-handed. It is time the pattern was changed in order to catch up with the progress that has been made in the interval.

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With the Government assuming responsibility for so much of the cost of medical education, and almost the whole of a doctor's pay (and pension), the public will sooner or later force a pattern of practice on a protesting profession. This is always a humiliating spectacle and provides a solution that is always makeshift. That is why I hope general practitioners will quicken the pace of change, and think, as many others do, that practice in groups is one of the ways of professional salvation.

The other and more important way is to make sure that the time and effort of the highly trained medical man are not wasted. Much of what he does now can be well done by others. And sooner or later a bold Government will discover that one method of making both patient and doctor more responsible in their relation to each other is by the token exchange of small pieces of metal—an unpopular view, but one that is bound to prevail in the long run. No one appreciates anything he gets apparently free. A give-away is always suspect.

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A new way of looking at health has been provided by Dr. Clifton K. Meador, of Birmingham, Alabama (*New Engl. J. Med.*, 14 January 1965). Because disease can be classified into syndromes and entities it is a mistake, he suggests, to look upon health or non-disease as "all encompassing and without specificity." From this he boldly stakes a claim for subdividing and classifying "non-disease" into syndromes and entities.

When I first read his article I thought it might be an elaborate leg-pull. He looked at the records of patients referred with a specific diagnosis which was, however, not confirmed by examination and tests. He gives the example of a "slightly obese, middle-aged woman with facial rounding, ruddy complexion, and prominent hair on the upper lip." Appropriate tests excluded Cushing's disease. In fact *no* disease was found. The logical diagnosis was that the patient had "non-Cushing's disease." And his article ends thus: "Treatment is always easy if the diagnosis is correct and non-disease clearly established. Stated simply, the treatment for non-disease is never the treatment indicated for the corresponding disease entity. In this statement lies the ultimate value of the science of non-disease."

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By leaking cars I meant cars that don't keep the water out when it rains, water that comes dripping on to the floor, often on the passenger's side. Complaints still come in about cars that do this, cheap and dear. One correspondent writes: "Got to be nasty to have them remedied."

PERTINAX