Personal View

I imagine that at some time most doctors are asked by their patients, "Why did you do medicine? Did you always want to be a doctor?" My dull reply has been that the first job I had was in a bank, where I earned £1 a week, too embarrassed to add that I spent more time than I should have done in the attic reading the *Daily Worker*, which in 1942 was campaigning for the opening of a "second front" in Europe. A bonus was the weekly science article written by J. B. S. Haldane. Also at about that time I played the organ at a rally held in a local cinema to support the same cause, where Harry Pollitt, secretary of the British Communist Party, was speaking. I had never played the cinema organ before and Mendelssohn's "Songs without Words" did not arouse much enthusiasm or match the oratory which followed, but at the end of the meeting a deafening "Red Flag" with all the stops out was great. Afterwards he gave me a signed copy of Friedrich Engels's *The Origin of the Family*. I would like to claim that this book inspired me to become a family doctor but it was not so. After a year my wage at the bank was increased to 25s., but I left to join the R.A.F.

R.A.F. pilots were not being lost at the rate which had been expected, and during a bottleneck in my training I was attached to the Aptitude Testing Unit in Bulawayo, in Southern Rhodesia. A biologist who was working there, Dr. Parry Jones, asked me what I intended to do after the war. I had no plans. He told me to go on leave for a week and do some thinking. I chose medicine. I have never seen him since, but I often think of him and of the many Rhodesians who gave us generous hospitality and am saddened by the estrangement of our two countries.

And so into medicine. There would be changes in medical care and my generation intended to take part in the revolution. We saw many of our elders object vigorously to the proposed National Health Service, which we knew to be so necessary, and were saddened by their views and puzzled when they meekly joined the Service on the appointed day. Things did improve, but the change was slow.

As far as general practice was concerned, no Government was prepared to pay more than lip service to its survival until recently. There was a new time dimension—and new names. I learned of the quinquennium whereby the university seasons were slowed to a five-year cycle. "It is too late to consider for the next quinquennium; perhaps the one after that" was a common "put-off" when we tried to press the universities to take an interest in general practice. Five years seemed a long time to wait, but then came the frightening discovery that a more realistic time scale was even longer than this, perhaps four quinquennia or half a working life-time. Many of the changes in organization which are hailed as revolutionary today could have been carried out 20 years ago. Indeed, Lord Dawson had suggested the health centre in 1920. For good or bad, the same time-scale seemed to apply to therapy too. Abandoning hormones, we now suppress lactation, as did our forebears, by tight binders and restriction of fluids. It took 20 years for anticoagulants to be regarded as superfluous in the treatment of cardiac infarctions. Will the coronary care unit take so long to die?—I fear it may.

What are the prospects for the idealists entering general practice today? In some ways they are fortunate for they can climb on the shoulders of many dedicated practitioners who, despite adverse working conditions, have raised general practice in Britain to a special position in world medicine. But those undertaking vocational training are voluntarily foregoing a £5,000 salary in the first decade of their professional work in order to do so. How long will it be before this anomaly is rectified; perhaps another 10 years? The Wessex scheme can be considered the first of the modern training courses, and it began in 1959.

The revolution in general practice is, of course, essentially in the field of organization and it is too early to say what long-term effect there will be on patients and doctors. It should improve medical care and encourage a spin-off in clinical research, such as epidemiology. Paradoxically, it has been the revolution in biology which has most influenced my thoughts since I qualified: Lorenz's *On Aggression* and his other writings, Robert Ardrey's *African Genesis* and *Territorial Imperative*, the various contributors to Desmond Morris's *Primate Ethology*, and in their special fields of human sexual behaviour and physiology the studies of Kinsey, and Masters and Johnson. (I find it inexplicable that many schools still do not include this "new biology" in "A" level courses.) The pupils of Tinbergen and Lorenz are already applying the techniques developed for animal and bird observation to children and the process is no doubt spreading to other captive groups.

But has the general practitioner any place in this ethology? He cannot avoid being involved in human behaviour and with his privileged knowledge of people and families he is in a special place—indeed a unique one—to make such studies. There are many facets of human development and behaviour which could be studied in general practice and which might lead to a new approach to the psychosocial problems which so occupy our time and bemuse us. The idea is not new to doctors. Dr. Scott Williamson, in an article in the *Lancet* in 1946 on "Health Centres of Today," clearly distinguished between pathology, the study of disease, and ethology, the study of health. "Let us call this branch of biology—ethology," he wrote.

But the unconventional road is hard and runs indiscriminately among academics, intellectuals, planners, politicians, gamblers, and cranks. After several years of promising planning a project on Teesside along these lines failed at the last moment, one reason being that doctors were suspicious of anything but the traditional approach to medical problems—and perhaps a territorial threat too. Yet surely a new look is possible. I find the prospect of sitting passively for another 20 years prescribing tranquillizers and antidepressants most daunting. If the psychosocial problems were a neat segment of our work it wouldn't be too bad, but they influence the presentation and management of so many illnesses we see.

What we are after is a change in attitudes, not just to illness but to living. There must be other ways. They may be as unproved as the drugs and psychotherapy of today but let us try. We must become more interested in the cohesive forces of our society. The traditional ethologist analyses behaviour in detail. The G.P. ethologist should not only study behaviour, but synthesize what is known in the fields of medicine, sociology, and ethology. The general practitioner is still well respected and can influence family behaviour. He has always done so to some extent. Dangerous, frightening, unethical? It cannot be worse than the changes in behaviour ensuing from drug therapy today.

And the irony of all this is that I am in private practice—not in the revolution and with no captive population. Just as well, your readers may judge.

Teesside

AUBREY COLLING
General Practitioner

Br Med J: first published as 10.1136/bmj.1.5742.227 on 23 January 1971. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.