FIRST DAVID BRUCE LECTURE IN THE DAVID BRUCE TRADITION *

The evolution of General Practice in the British Army

DR JOHN FRY, OBE, MD, FRCS, FRCGP

It has been my privilege to be associated with general practice in the British Army for over 20 years. It all began when Robert Drew and I both used to attend combined medical rounds at Guy's Hospital on a Friday afternoon. I was a G.P. seeking to keep up with clinical medicine and Robert then was Commandant at the Royal Army Medical College at Millbank. He asked me for my opinions on general practice in general and on general practice in the Army.

Since then I have watched with admiration the steady progress and development of general practice in the Army. It has shown what can be achieved with sound sense, perseverance, perspiration, application, demonstration and inspiration.

Starting just a century ago David Bruce showed the same characteristics and followed similar principles in dealing with somewhat different problems in outlying parts of our then great British Empire.

David Bruce — earliest days.

David Bruce was born in Melbourne, Australia on 29 May 1855, the only son of a Scottish engineer then working in the goldfields. When he was 5 the family returned to Scotland and David attended Stirling High School. He left school at 14, started on a business career in Manchester, developed pneumonia and went back home. He must have decided on a different way of life because next he enrolled at Edinburgh University and after starting on a course in zoology he switched to medicine and graduated MB, CM. in 1881.

David Bruce in General Practice

Soon after qualifying Bruce worked as an assistant to Dr. Stone, a general practitioner not far from Millbank — in Reigate, Surrey. Reigate then was a country town of some affluence, some of the beautiful old buildings can be seen still.

David Bruce must have enjoyed his two years in general practice and possibly would have continued there patiently waiting for a partnership.

Reigate was to play an important part in Bruce’s life in other ways. He met, courted and married Mary Elizabeth Sisson Steele, the daughter of another local general practitioner.

The young couple found it impossible to manage on the low salary of an as-

* The inaugural David Bruce lecture was delivered by Dr J Fry, Honorary Consultant in General Practice to the Army, on 12 Jan 1982, at the Royal Army Medical College, Millbank.
sistant without a view to early partnership. He decided to do what other young doctors in those far off days did, he joined the army for the pay in 1883. Would we have done likewise a century later?

A Happy Marriage
It is important here to mention the very happy and successful married life of David and Mary Bruce for almost 50 years. They died within four days of each other, a few yards from Millbank in Artillery Mansions in November 1931. (Figs. 1 and 2).

Mary Bruce was a wonderful Army wife, which in those days was tough and hazardous. But she did much more. She accompanied her husband overseas and acted as his technician, operating sister (at the siege of Ladysmith for which she received a decoration), aide-de-camp, illustrator, secretary to many commissions that he chaired and above all as a constant loving companion.

David Bruce as Pathologist
David Bruce is best known for his remarkable researches in discovering the nature and causes of many diseases. After a year in the Army interests turned to pathology and epidemiology.

He studied Malta Fever and discovered the causal agent and demonstrated its association with goats’ milk. (Fig 3 and 4).
In South Africa he discovered the trypanosome and demonstrated its causes of Nagana and sleeping sickness, and their association with tsetse fly bites. (Fig 5 and 6).

His work was very much in the wide general practice epidemiological field and he showed very clearly the relationships between man, his environment and disease. Although he did so in the special climates of Malta and Africa his examples can be applied to the present time. The major and common diseases of our own time almost certainly have their foundations in our own personal environments—cancers, heart disease, mental disorders and even everyday respiratory infections—excessive smoking, drinking, eating, stresses and unmet ambitions and desires (promoted by the media).

**Sir David Bruce at Millbank**

For his work Sir David Bruce received numerous honours and decorations—his insignia and medals are on display at this College—including the Gold Medal of the Royal Society.

In 1914 although on the retired list he was asked to become Commandant at the Royal Army Medical College, Millbank, and he played an important part in training medical officers during the First World War. He remained Commandant until 1919.

**The Army in Peace-time**

Since 1946 we have been at peace. What a peace some may say! With the cold war state in Germany, with the troubles in Northern Ireland, in Rhodesia, in Belize and even here at home — who can say that our world is peaceful!

The primary role of any army must be a readiness for non-peace. That is what the Army is for and that is what medical officers in the Army are there for.

However, a peacetime army is also very much part of our society and our community. It must be influenced by and involved in the social changes. It is not surprising, therefore, that the National Health Service and the renaissance of general
practice have had profound changes on medical and health care in the Army.

The army general practice system could, and should, serve as a bridge linking the service and society as a whole.

**Changes in the RAMC**

I mentioned my earliest associations with Robert Drew from our chance contacts at Guy's Hospital — my old medical school.

This led to informal and more formal meetings and discussions about the problems of general practice and of general practice in the Army in the early 1960's.

The problems of British general practice at that time were that it was a cottage industry, in low morale, of questionable standards, with little planned training and education, few resources and with very little information or data on what it was all about.

The problems of general practice in the Army were even greater — it just did not exist! Serving soldiers and their families in West Germany were complaining to their Members of Parliament and questions were being asked. There is no greater stimulus to British action than a series of questions to a Minister in Parliament!

The complaints were that there was no family doctoring as in civil practice, That Army doctors did not understand how to manage wives and children. That the structure where regimental medical officers attached to units did not relate to families was one that led to confusion.

What happened next was what might have been expected. I was invited to visit BAOR. I did so, I produced a report suggesting a different emphasis of organisation, a framework for general practice as a special branch of health care in the Army, with its own directorate, practice organisation, training programmes and a department at Millbank.

On my return I wrote a paper for the Lancet (Fry 1963) entitled — "General Practice in BAOR — practice in an ideal setting" in which I noted the very special opportunities for good general practice with excellent resources, back up from SSAFA sisters, orderlies and consultants.

To my surprise all my recommendations were accepted and I was invited to become Consultant in General Practice to the British Army — the first such appointment in any of the services. (The RAF and Royal Navy followed in that order later).

**General Practice in the Army**

The beginnings were far from easy and straightforward. Who should be trained first and how?

We started at the top. We organised visits for Colonels and Lieutenant-Colonels to some of the best practices in Britain over 2 and 3 month periods. I would have welcomed such opportunities to meet and observe the leading British GP's of that period.

The scheme was only a partial success. The Colonels, charming as they were, had no appreciation of the renaissance taking place in general practice. They were thrown in at the deep end and they sank.
It was through the wisdom, support, perseverance and finesse of the many DG’s and Commandants that general practice in the British Army slowly blossomed and bloomed.

Robert Drew was the initiator as Commandant and then Director General. Director Generals Knotts, Baird, Talbot, Bradshaw and presently Sir Alan Reay, Generals Mences, Stephens, Carrick, Gavourin, Matheson and Evans have all been more helpful, understanding and supporting. I owe them all, and many others in RAMC do to, many thanks for what they did to promote general practice.

Progress of general practice in the Army has been made by Ken Young and Tommy Bouchier-Hayes. This remarkable and complementary pair created one of the best vocational training programmes for general practitioners in the UK. They created the most popular over-subscribed MRCGP course in the UK. They created high morale among Army GPs and undoubtedly the quality of care in Army general practices has improved considerably.

In their earlier days there was a third member of the team from the RAF — Alistair Moulds, no less remarkable with a flair for producing teaching programmes. His talents have developed further in civil practice with books on how to pass MRCGP and PLAB exams, written together with Ken Young and Tommy Bouchier-Hayes.

The Department of General Practice continues to flourish with Gil Kilpatrick and Alan Warsap in charge.

It is noteworthy, that just before Ken Young retired from the Army he was appointed Director of Army General Practice and promoted to Brigadier.

In retrospect the recognition of general practice as a special branch equal with medicine and surgery by the Army is remarkable since it has taken less than 15 years from its original conception.

In this recognition of general practice as a “specialty” the Army has once again demonstrated prescient leadership. There have been discussions and debates within the profession about a possible specialist register. The Army has demonstrated how the speciality of general practice should be recognised, it must follow by recognising trained general practitioners as equal specialists to physicians and surgeons by giving them equal recognition.

Present State — a critique

Much has been achieved, much needs to be done.

Quite properly the initial efforts of the department of general practice have been in setting up a first-rate system of vocational training for general practice.

The programme is good, the organisation is sound, the direction is excellent, the trainers are experienced and well briefed and one objective measure of the trainees is their above-average pass rate for MRCGP examination.

Understandably, less attention has been paid to develop continuing education for general practitioners in the Army.

Continuing education has been taking place but its usefulness is uncertain. Most tends to be based on traditional methods involving medical and surgical specialists giving teaching sessions to GPs. There also are small groups using audio-visual media and other forms of learning.
Trainers and trainees, probably, are well catered for, but it is the two thirds or so of Army GPs who are not involved in the vocational training programme who need special attention.

Continuing education for the GP uninvolved in the vocational training must be reassessed as a priority.

It may be helpful to set a small review group to look at this field and to make recommendations. We need to know.

a. **who** requires continuing education and **where** they are.

b. **what types** of continuing education are most useful and appreciated and **how** best it may be organised and provided.

c. **when and where** it can be organised, bearing in mind the awkward placement of many army GPs.

d. **who** should organise the programmes centrally and locally and **how** may the results be assessed.

There should be general practice academic representation at Millbank, as there is in civilian academic medical instructions. There should be a professor of general practice at the College, as there are professors of medicine and surgery. There has to be a general practice representation on the College Council.

General practice is a new-old specialty lacking in a detailed core of scientific knowledge. Much of the basic information and data used comes from other specialties and is useful only up to a point.

**Research** is very necessary to provide extra information and data on general practice activities and on the nature of disease in this field.

For example, there are very many “bread and butter” conditions that are seen and managed almost exclusively in general practice, such as the common respiratory disorders and most psychosomatic problems. The other specialists will see and manage only those proportions of asthma, hypertension, duodenal ulcer, anaemia, diabetes, rheumatic disorders that we care to send them. We have a much better picture of the true spectrum of disease than do others. We cannot assume that textbooks written by other specialists are appropriate for us.

There is great need to collect, study, analyse and apply data and information from general practice.

It is necessary to look into —

a. **operational facts** on what we are doing, how, why, where, when and to what effect. We need to produce **personal work profiles** on ourselves to discover how we differ from one another and why. We need to set up trials and experiments to see whether we might carry out our work more effectively, more efficiently and more economically.

b. **clinical research** is necessary to study the particular clinical problems of general practice. What are the best ways of managing young men with acute sore throats, children with earache, women with urinary tract infections and persons with recurrent headaches?

c. **clinical research** is necessary to study the particular clinical problems of general practice. What are the best ways of managing young men with acute sore
throats, children with earache, women with urinary tract infections and persons with recurrent headaches? In the Army research should be carried out at the primary level on factors that make for the health and efficiency of soldiers and officers; research is also required to test out and evaluate the optional ways of providing primary care! it should not be assumed that the British type civilian general practice is the best for the Army.

The methods and tools of research in general practice need be simple and cheap — questioning critical minds posing relevant questions and seeking answers are more important than computers and statisticians.

Again, it may be useful to set up a small review group to report on the subjects and methods appropriate to research in general practice in the Army and how it may be facilitated and supported.

Closely related to continuing education and research are standards and quality of care. We have heard and read about audit and peer-review, but little of much value has emerged.

This subject has been made over-complex with too much small print thinking and doing.

Essentially what we are seeking are ways of providing each of us in clinical practice with information and data on our performances in relation to certain agreed targets of excellence. We need to develop the concept of confidential personal profiles.

Such profiles should include operational data on work patterns — including volume of work, prescribing, use of diagnostic facilities, referrals to other specialists and hospital admissions. They should also include information on clinical activities such as diagnostic labelling and outcomes of management.

The organisation of general practice in the British Army is such that these research activities could be introduced and carried out without much difficulty. They would require the collaboration of general practitioners to record the information plus a system of collections and analysis, followed by regular feed-backs to the GPs.

Such feed-back profiles would be excellent topics for local discussion and as means and triggers for more relevant continuing education.

**General practice in the David Bruce tradition**

David Bruce was a wonderful demonstration and example of my thesis. He showed this one hundred years ago, in days of pencil-paper type of research based on original ideas and incentives. With careful observation and recording, and examination of and tests on specimens. With analysis of the findings and consideration as to their meaning and relevance. Finally, the real benefits coming from application of the results to provide better care for our patients and to develop systems and methods that may be more effective, efficient and economic.

There is nothing to stop us following in David Bruce's tradition. General practice is crying out for simple fact finding studies — most still require only pencil and paper.

We have created an excellent educational training programme for young medical practitioners in the Army. Now, we need to introduce a more questioning and critical approach to our work.
David Bruce, surely, would have encouraged us to look more closely at ourselves as front-line clinicians working with conditions, problems and situations on which still much is unknown and to which much knowledge can be added through our own efforts and application.

Envoy

It has been a great privilege and honour for me to be associated with general practice in the British Army. I have straddled the period from its conceptual origins, when a small seed was planted, it did fall on fertile soil, it has been carefully nurtured by many excellent medical Army gardeners and now it has grown into a sturdy plant with firm roots and fine flowers.

I have acted more as an activating and stimulating catalyst. I have supplied others with ideas and they have carried out successful actions and exercises.

This lecture not only is a tribute to the past memory of Sir David Bruce but also is a tribute to present generations of Army general practitioners who have achieved so much, but also in confident expectations of further future progress.

Honorary Consultants

To The Army

Professor Ian McColl, FRCS, FRCSE, was appointed Honorary Consultant in Surgery to the Army with effect from 31 Mar 1982, in succession to Professor A J Harding Rains, who has retired.

Professor Francis W O'Grady, TD, MS, BS, MD, FRCP, FRCPath, was appointed Honorary Consultant in Microbiology to the Army with effect from 25 Nov 1981. This is a new appointment.

Dr J M Cooper, PhD, FCST, was appointed Honorary Consultant in Speech Therapy to the Army with effect from 15 Feb 1982, in succession to Miss C E Renfrew, who has retired.

To The Queen Elizabeth Military Hospital

Mr T D Cochrane, MB, BS, LRCP, FRCS, was appointed Honorary Consultant in Plastic Surgery to the Queen Elizabeth Military Hospital with effect from 1 Jul 1982, in succession to Mr A Wallace, TD, FRCS.

Mr R Q Crellin, FRCS, was appointed Honorary Consultant in Orthopaedic Surgery to the Queen Elizabeth Military Hospital with effect from 1 May 1982, in succession to Mr J Buck, who has retired.

Mr J N G Evans, MB, BS, FRCS, DLO, was appointed Honorary Consultant in Otorhinolaryngology to the Queen Elizabeth Military Hospital with effect from 26 Sept 1982, in succession to Mr J C Ballantyne, who has retired.

To the Army in Hong Kong

Professor J C Y Leong, MB, BS, FRCS, FRCSE, has been appointed Honorary Consultant in Orthopaedic Surgery to the Army in Hong Kong with effect from 14 Jun 1982, in succession to Dr A R Hodgson, who has retired.