

THE SIR DAVID BRUCE LECTURE, 1994

A Matter of Principles

15 November 1994, Royal Army Medical College, Millbank, London SW1P 4RJ

Professor P Freeling

OBE, FRCGP

This memorial lecture addresses three tasks. The first is to celebrate the work of a great man, Sir David Bruce, who made enormous contributions both to humanity at large and to the Royal Army Medical Corps of which he was such an eminent member. The second task is to derive lessons from Bruce's life and work, and the third is to merge those lessons with examples from my own experience and show their relevance to the work of General Practitioners (GPs) today and tomorrow. In short, the lecture will not only commemorate Sir David Bruce but also attempt to prove Henry Ford wrong when he said that history is bunk whilst bearing in mind George Santayana's dictum that those who cannot remember the past are doomed to repeat it.

David Bruce was an only son, born in Melbourne, Australia on the 29th May 1855. To place you in his historical context this was the year in which Florence Nightingale introduced hygienic standards to military hospitals in the Crimea and London's sewers were modernised after an outbreak of cholera. It was also the year in which Livingstone discovered the Victoria Falls.

Bruce's father, a Scots engineer, had gone to Melbourne, with his wife Jane, formerly Hamilton, to supervise the installation of rock-crushing machinery. The family returned to Scotland when David was five years old and he was educated till the age of 14 at Stirling High School in his mother's home town. David then went to work in a warehouse in Manchester. He there contracted pneumonia which somehow lead to his entering Edinburgh University in 1876, apparently with the intention of graduating in Zoology. Perhaps he was diverted into medicine by Robert Koch's discovery in that year of the anthrax bacillus. In the event Bruce qualified MB CM in 1881, the year in which punishment by flogging was abolished in the British Army and the Royal Navy.

As so many Scots graduates did, Bruce came south and worked as an assistant in general practice to a Dr Stone in Reigate, Surrey. There he met and married Elizabeth Sisson Steel the daughter of Dr Stone's predecessor in practice. The marriage was to last for the remaining fifty years of their lives with David Bruce dying on the 27th November 1931 four days after Mary Elizabeth and whilst her funeral was taking place.

In 1883, the year in which Robert Koch described a method of preventive inoculation against anthrax, David Bruce joined the Army as a surgeon. Throughout their lives he and his wife were a working partnership with Mary accompanying David not only to all his military

stations but also on his working trips in Africa. Indeed, Mary was later described as a better technician and microscopist than her husband and she became OBE in her own right.

David Bruce began his brilliant Army career by passing out at Netley at the head of the list. This was only the first of a series of achievements, at least three of which are of immense and international importance. The first is Bruce's work on Malta fever. The second is his work with the three forms of *Trypanosoma brucei*. The third is Bruce's contribution to the reduction of deaths from tetanus amongst wounded in the trenches during the First Great War.

Let us turn to Bruce's discovery of the causal organism of what is now called brucellosis. Bruce was posted to Malta in 1884, the year in which Arthur Nicolaier discovered the tetanus bacillus. At that time being posted to Malta meant being put at risk of contracting undulant fever, also known as Malta Fever, with its characteristic splenic enlargement and protracted, sometimes fatal course. The condition reached an incidence of 25.6/1,000 amongst the military garrison. Its occurrence was blamed on miasma or on "humid exhalations arising from the sea".

By December 1886, the year in which the Pasteur Institute was founded in Paris, Bruce had identified a fastidious micrococcus from the spleens of each of 5 fatal cases of the condition. In May 1887 he tried by failed to identify the organism in fingerprick blood from 10 patients suffering acutely from the condition. Bruce was conducting a series of scientific experiments in which each was intended to examine or explain the findings of the one preceding it. He and his colleagues were applying rigorously but imaginatively the methods described by the German microbiologist Koch for identifying the specific causes of specific diseases and so proving them to the infections and enabling preventive measures to be developed.

What are now termed Koch's postulates had appeared in English for the first time in 1884 in an anonymous BMJ editorial (1). The so postulates addressed the matter of being able to demonstrate that a given bacterium is the cause of a disease. To do it must be proven:

1. that a special bacterium with definite characteristics marking it out from other forms of bacteria, is constantly present in the parts affected;
2. that this bacterium is present in sufficient numbers to account for the disease;

3. that it is not similarly associated with other diseases;
 4. that this bacterium can be cultivated apart from the body;

5. that its introduction into lower animals is followed by the same effects as the introduction of the infective material itself.

Bruce and his colleagues were soon able to demonstrate that the organism produced the disease when inoculated in to monkeys. It was more tricky to identify undulant fever from other febrile disorders found in the Mediterranean littoral. This became much simplified in May 1899 when a Maltese doctor, Themistocles Zammit, applied Widal's method of serum diagnosis to the fever and demonstrated that microscopic coagulation of Bruce's micrococcus occurred when it was admixed with the serum of a patient suffering from undulant fever.

It now seemed beyond question that undulant fever was the result of human infection with the micrococcus which came to be called *Brucella melitensis*.

It is interesting to note that David and Mary Bruce spent their leave in 1888 studying bacteriology under Koch. In 1889 Bruce published in the BMJ his paper entitled "Observations on Malta Fever" (2). The progress he reported was due to a combination of native wit and persistence, to having the advantage of being married to a gifted colleague, and to the applications of methods, the scientific nature of which we would accept today.

Nevertheless, notions concerning "emanations from decomposing organic matter" are still mentioned in Bruce's paper and the source of infection and the nature of transmission of the disease seemed to defy elucidation. Indeed, incontrovertible evidence that goats were the animal reservoir from *Brucella melitensis* came partly by accident.

1905 was the year in which Albert Einstein formulated his Special Theory of Relativity and established the law of mass-energy equivalence and Sigmund Freud published "Three contributions to the Theory of Sex". 1905 was also the year in which Robert Köch received the Nobel Prize for Medicine. In that year Zammit was able to show that the blood of Maltese goats reacted to his agglutination test and went on to isolate the micrococcus *melitensis* in pure culture from goat's blood. More dramatically, in the summer of that year a herd of 60 goats was shipped from Malta to America via Antwerp on SS Joshua Nicholson. During the voyage most of the crew drank goat's milk. Those who drank it developed undulant fever, those who did not remained well. In addition, the micrococcus *melitensis* was found in the milk of several goats. Finally, although the goats were kept in strict quarantine in America, all eventually developed severe manifestations of what many people still insisted was a disease confined to human beings.

The Army authorities had accepted the findings of Bruce and his colleagues but, although pasteurisation of the goats' milk would have been effective, the garrison was provided instead with condensed milk and forbidden

to drink goat's milk. The consequence was the virtual elimination of Malta Fever among the garrison personnel but its persistence among the civilian population. A series of preventive steps were recommended to the civilian authorities in 1912. These included making undulant fever notifiable, banning goats from towns, setting up a network of small laboratories to perform serum tests on goats with slaughter of those proven infected, supervision of the milking of goats, and instructing the public always to boil goat's milk before drinking it. Had these recommendations been followed undulant fever would have been eliminated from Malta. In the event it was not until 1938 that pasteurisation of goats' milk became a statutory requirement and it is quite likely that it was the Second World War siege with its consequent slaughter of goats for food at last virtually eliminated undulant fever from the island of Malta.

It is plain that David Bruce understood the explanatory nature of the scientific method. It is equally plain that he encountered the reluctance of the public and indeed of doctors to accepting changes dependent on research findings and that his experiences with *Brucella melitensis* will have taught him something of the importance in medical care of the vagaries of human nature. He will have been made aware on one hand of the need to take into account the effects of culture and changes in it when deciding on the ways in which we will practice and on the other hand on the effects that medical interventions have on the society which surrounds us.

Let me turn now to Bruce's work on trypanosomes. He began this work in Zululand 1984 with studies of Nagana, a disease of cattle, which he demonstrated to be caused by a trypanosome, and to be transmitted by the bite of the tsetse fly from a reservoir of infection among wild game. The Boer War intervened and it was not until 1903 that Bruce became again involved with trypanosomes which he demonstrated to be the cause of sleeping sickness and also transmitted by the tsetse fly. Bruce identified three types of what are now named in his honour *Trypanosoma brucei*. He established that *Trypanosoma gambiense* caused sleeping sickness in Gambia, and *Trypanosoma rhodesiense* caused it in Rhodesia whilst the original *Trypanosoma brucei* caused the disease in cattle but not in man. He established also that the main reservoir in Gambia was man, whilst in Rhodesia it was animals. These differences suggest, of course, different approaches to controlling spread of the disease as does identification of the insect vector involved. The ability of *T. brucei* trypanosome to undergo antigenic variations meant that there has even now been little progress in the development of a vaccine against sleeping sickness. It is true that modern chemotherapy is reported to be effective in the acute phase of sleeping sickness but 12% of children with advanced sleeping sickness are seriously disabled after being cleared of parasites and a further 30% have some residual neurological problems. Control measures are still based on major social and zoological

interventions themselves based on Bruce's findings. Whilst these cannot produce perfect results, a disease which used to cause hundreds of thousands of deaths annually now causes far fewer, although, admittedly, it is uncertain how much of the reduction is the result of prevention and how much the result of a natural change in the behaviour of the organism.

There can be little doubt that Bruce was a man of forceful mind, capable as are all good researchers of extreme but logical simplification. It seems to me that some of this ability originated in part from his secure belief in, and imaginative application of, the principles originally enunciated by Koch, the father of microbiology.

I turn now to Bruce's work on tetanus. Bruce commanded the Royal Army Medical College throughout the First Great War. His insistence on the early use of anti-tetanus serum seems to have helped reduce the death-rate among cases of tetanus by two-thirds between 1913 and 1917, but, as he writes rather plaintively, improvement in the initial surgical treatment of wounds could have resulted in the elimination of cases of tetanus if only it could have been brought about. What was being used was heterologous antitoxin with its risk of anaphylaxis and Bruce would have known that he was trading off one kind of risk against another. In the Second World War the lessons he learnt in the First were applied by British and American Services with all servicemen actively immunised against tetanus and primary surgical debridement being conducted as near to the front line as possible. As a consequence there was a virtual absence of the disease among the Allies whilst it still occurred in the fighting men of other countries. It is clear that good preventive care of the infections was feasible even before the advent of the sulphonamides and antibiotics but its acceptance may have been driven by fear rather than upon good communication and successful prevention may eventually remove the fear and thus the motivation.

I hope to have made clear from this quick scan of some his work that Bruce lived in exciting times and seems to have enjoyed not only the need to respond to changes produced by others but also the opportunity to himself produce change.

We can all empathise with the notion that coping with changes produced by others is stressful. Most of us know that to cope with such change, individuals and the system in which they work must both be flexible. I hold that to be flexible and successful both individual and system must have a firm underpinning of basic principles.

I hope to have made clear that David Bruce's success in meeting the challenges of change stemmed not only from his own character and innate ability but from his ownership of a set of fundamental principles based on Koch's postulates, to which he could return if he found himself in difficulties. I have attempted to highlight Bruce's recognition of the explanatory nature of the

scientific method. I have attempted to show that he was faced with the reluctance of the public and indeed of doctors to accept research findings. I have attempted to illustrate how the effects of the vagaries of human nature delayed or limited the application of his work. I hope I have justified the principle that we must take into account the effects of culture and changes in it when deciding on the ways in which we will practice. Finally, I have attempted to highlight from Bruce's experience that need for medical practitioners to be aware of the effects our interventions may have on the society which surrounds us as well as the effects on the individuals who comprise it.

I drew the title of this lecture from the matter of fundamental principles. I intend now to present to you principles which I consider fundamental to general practice, principles which general practitioners will ignore at their peril. I will attempt to illustrate these principles from a clinical lifetime spent in general practice in the National Health Service. To place that experience in historical relationship to Bruce's work I should perhaps mention that when I entered general practice in 1957 we were immunising infants against tetanus but still using anti-tetanus serum for wounds in the largely unvaccinated population at large.

With the advent of tetracyclines some of us became courageous enough to omit the ATS and, thank God, within a relatively short space of time we were dealing with a vaccinated population rather than an unvaccinated one.

The nearly 40 years since I entered general practice have been exciting and challenging for any GP wherever in the world the doctor practised and whatever the system within which care was provided. The source of the excitement was similar to what must have excited David Bruce. It was the making of simple observations and the opportunity of trying to fit explanatory models to them. I can say with some national chauvinism that those observations and explanations were almost all made in British General Practice, and I would hold that before we turn to other countries for the source of new wisdom we would do well to reflect on our own history and present practice.

Let me begin by saying that General Practice must above all be culturally responsive. I have already mentioned the notion of cultural responsiveness. It is fundamental to everything which I am saying this evening that whilst all doctors must be aware of the society in which they live and practice it is General Practice more than any other clinical discipline which is sensitive to cultural change. The service we provide and the content of our practice has to respond to social change and to technological change, as well as to changes in medical science. I should state in passing that culture, as I have shown in discussing David Bruce's work, is, immensely important in Public Health medicine. There is, however, a major difference: in Public Health Medicine they try to

manipulate norms, in General Practice we have to respond to them.

When I first began to practice the social expectation was of having a personal doctor, the GP. As far as mothers, children, and the elderly were concerned this had been a privilege denied the working classes of this country until the NHS was introduced, along with other fundamental social legislation, in and around 1948. We GPs spent the first twenty or so years of the NHS trying to deal with the consequences of this extension of privilege. The legislation enshrined the provision of health care through a two-tier system with a personal doctor rather than going over to a public health model working out of polyclinics.

As a consequence, the essential unit of first contact medical care remained a consultation with your own doctor. The consultation was defined by Spence as "...when, in the intimacy of the consulting room or sick room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts" (3). Through the 1960s there were reasons for believing that the GP was the person best placed to establish this kind of trusting relationship.

In January 1967, the late William Thompson wrote: "The doctor-patient relationship is the basis of good general practice. This truism, which has tended to be submerged during the last two decades of medico-political controversy and increasing specialisation, is now being recognised" (4). I would reiterate that statement today. We need of course to define what we mean by good general practice and to stipulate what we mean by the doctor-patient relationship. In the early 1960s Kevin Browne and I defined the special function of the general practitioner as understanding the whole of his patient's communication (5). It became clear over the next decade that aiming to understand the whole of a patient's communication was over-ambitious and in 1976 we stipulated that our aim as GPs should be to provide whole **problem** care not necessarily whole **person** care (6). The term whole problem care avoids any conflict due to recent social changes which have led to the gross and nonsensical misuse of the term holistic medicine as involving so-called alternative medicine and embracing everything from proper care based on science to aromatherapy and reflexology. Be that as it may, for my purposes today, good general practice is the practice of whole problem care and my operational definition of the doctor-patient relationship is the emotional and social environment in which communication takes place during a doctor/patient contact, normally a consultation. The outcomes and purposes of communication are of three types: informative, the conveying of information; promotive, the initiation of actions; and evocative, the arousal of feeling (6a). The doctor-patient relationship can affect all three types of outcomes from communication.

These three outcomes of communications always occur although sometimes not in the terms intended by the communicator.

Because communication has an evocative component there is a particular need to be able to treat the arousal of feelings as information, as language, rather than being triggered into an unthinking response or, perhaps worse, into a denial of having feelings at all.

I will use three examples, anger, anxiety and admiration. Anger most of us learn to suppress early. We should be trained to recognise but not respond to feelings of anger rather than to suppress them. As doctors we learn to control and to direct anxiety very early in our careers. It can be argued that the much resented rote learning tests to which we are subjected as students are one way of desensitising us to anxiety-producing situations and I suspect that switching to competency and skill testing will not reduce the trauma involved although it may alter the defence mechanisms which are erected. Unfortunately, many of us deal with anxiety by compulsive/obsessional techniques which may be quite destructive to one's personal and professional life. The result is, as part of another social revolution, now called occupational stress and any destructive outcome is called burn-out. My third example of emotion as information is admiration and I choose it out of a range of other emotions which are aroused in all of us by our jobs. These include sympathy, unhappiness and sexual feelings as well as admiration. Doctors are of course forbidden to respond to sexual feelings and its dangers are known to all of us. Less obviously dangerous may be that form of non-sexual seduction to inappropriate behaviour which originates in the doctor being conned by "Oh what a wonderful doctor you are!", an approach very likely to obtain favours for the patient. I am thinking of the kind of patient about whom receptionists say he/she is one of DrX's special pets. Flattery is sweet and like most sweets it is fattening... in this case to the consultation frequency and duration and some times to prescribing costs.

These very personal feelings and the notion of using them as incoming data which can be processed by the doctor and even fed-back to a patient, seems to me still obviously relevant to our work today.

I am perturbed that in the last few years the emotions aroused in doctors by patients with abnormal illness behaviour have been lumped together as the feeling of "heart-sink". Doing this seems to me unlikely to increase our ability to understand our patients and, worse, may seem to put the blame on them for any misunderstanding.

It is essential to emphasise that these simplistic statements about the use of feelings as information, together with avoidance of denial or repression of them, are related to the acquisition and demonstration of empathy. Empathy is a characteristic I believe to be essential to whole problem care and clinical general practice. It is defined in the Concise Oxford Dictionary as the "Power of projecting one's personality into (and so

J R Army Med Corps: first published as 10.1136/frame-141-02-02 on 1 June 1995. Downloaded from <http://milhanhealth.bmj.com/> on January 18, 2022 by guest.

comprehending) the object of contemplation". It is the ability to put oneself into another person's shoes and to feel whether or not they are too tight! I will return to the matter of empathy later.

In the fifties and sixties doctors who adopted the type of ideas I have been rehearsing did so in what were then called Tavistock Groups and have since been named after their great exponent Michael Balint. The explanatory models used were psycho-analytic in nature. Whilst these models are today out of favour, the observations made seem to me to remain startlingly true and the mode of learning, a led small group has become the hall mark of education in and for general practice.

I have been describing from the doctor's point of view what is after all a two way transaction in which the doctor is the paid professional and has responsibility for managing it. A major social change over the years has been in the degree of responsibility which we now expect of the patient. It is no longer enough to be a compliant patient; you need to be a proactive one. Underlying all these changes is the notion that with rights go responsibilities, with privileges go accountability. One consequence of this seems to me to be that people believe that medicine can do anything and that if medicine can do something it is everyone's right to have it done. All these changes in the social environment may have been unavoidable but their consequences have been predictable, yet I find my younger colleagues surprised by them. Incidentally, it seems to me possible that a volunteer armed service may attract people into its non-commissioned ranks who want to conform rather than initiate, who want to obey rather than command. You may not find that servicemen seek complete autonomy and I am sure that you will find that dependency is a necessary although temporary stage in an ill person's progress towards recovery.

Perhaps some of the problems in general practice today originate in our having, over the years, chosen psychologists rather than sociologists as our mentors. For practical purposes I see sociologists as interested in the similarities within collectivities of human being whilst psychologists are interested in the differences between the individuals who make up those collectivities. Sociologists may seem therefore to adopt a more balanced approach. They have adapted the models of the doctor/patient relationship originally offered by Szasz and Hollender in 1956 (7). Szasz and Hollander, like sociology itself, were concerned with the balance of power in relationships and offered three paradigms of the doctor-patient relationship: Doctor active - patient passive; doctor guiding - patient co-operating; and, mutual participation.

Friedson offered an extension of this paradigm to include: doctor passive - patient active; doctor co-operating - patient guiding and mutual non-participation (8). This extended sociological paradigm reflects of course social change over the years. Our population of patients is by and large better educated, more informed,

far more affluent and far less respectful of authority than were their parents and grandparents, or themselves as children among whom I practised in the 50s 60s and 70s and from whom I learnt the lessons I am discussing.

There has been a major loss of social authority by doctors, but this has not meant necessarily a loss of power for GPs. In my personal lexicon "authority" comes with the social role, it is donned with the uniform, it is given to members of a group by members of another group, usually a larger one. "Power" on the other hand I see as freely accorded by one individual to another and as idiosyncratic to the relationship between them. It is usually necessary to give up authority to obtain power. Power stems from a judgement of the person who gives it as to the other person's honesty of intention and competence. It is not easily earned and it can be all too easily attenuated.

I believe that the patient-initiated consultations which formed the bulk of the GP/patient contacts up until the mid 70s afforded many opportunities to earn power, many opportunities to achieve whole problem care. If nothing else we could share the anxiety of the patient who has chosen to consult us. I am certain that power is somewhat more difficult to learn in doctor-initiated contacts with patients, perhaps because one has used authority to establish the contact. I do not understand how power can possibly be earned by doctors in contacts which they delegate to others. Some at least would think of persistent delegation as a misuse of authority and a deliberate abrogation of power. Persistent delegation becomes substitution.

The sociological perspective began to inform GP thinking about communication and the doctor patient relationship at about the same time as technology provided us with relatively affordable reel to reel tape recorders and with microphones sensitive enough to be used unobtrusively in our consultations. This ability to audio record consultations unobtrusively led to a piece of research fundamental to our exploration of the doctor/patient relationship, to analysis of the consultations which take place within the environment of that relationship, and fundamental to an understanding of the doctor behaviours and preferred styles which affect the relationship. Those of you who have read their book "Doctors Talking to Patients" (9) will know that Pat Byrne and Barry Long divided consultations into six phases: the doctor establishes a relationship with the patient; the doctor seeks to (does) discover the patient's reason for attendance; the doctor conducts a verbal and/or physical examination; the doctor, the doctor and patient, or the patient consider the condition; the doctor (and occasionally the patient) detail treatment and/or further investigation; the consultation is terminated, usually by the doctor.

You will note that these phases still have the doctor as dominant in most of them and are unashamedly focused

on problem solving, with the assumption that the patient has initiated their own attendance.

Barry and Pat analysed audio-tapes of some 2,500 patients and write that the final form of six stages rarely appeared in practice and should be seen as an ideal.

Most of you will know that they went on to purvey the notion of a dimension of doctor behaviour in consultation which ranges from doctor-centred to patient-centred, that they produced from their observations a list of behaviours which permitted a doctor in a particular consultation to be located on that dimension, and that they offered a "DIY kit" for analysing consultations. Pat and Barry used small led groups to discuss the audio-tapes with the intention of changing doctors' styles to what were considered to be advantageous modes. Insofar as the doctor/patient relationship is concerned it seemed to me then, and still seems to me, that Byrne and Long shared the notions and perceptions of those of us whose initiation had been through psycho-analyst led groups, although Barry Long's background was very different. It seemed to me, above all, that they recognised that consultations for different purposes might well need different styles and, that whilst behaviours might change with purpose, the doctor/patient relationship needed to be fostered so that, to draw a caricature, a patient would be grateful both for the way the doctor broke bad news and the way he responded to good news.

Out there in the wider world which embraces general practice and is served by GPs, rapid changes were taking place. Despite changes in Government and variations in levels of employment there was in general a huge increase in affluence.

In Southern England at least the affluence was based on families having two incomes. We were providing whole problem care for working mothers and their children, for working non-mothers, and for a whole universe of change in sexual mores and methods of contraception. There continued to be a steady hacking away at social stratification and there was beginning a deification of entrepreneurship which, whilst it had the potential social benefits of increasing mobility between classes, also altered value systems in ways which I believe we are already coming to rue.

Alongside these social changes were rapid changes in medical science accompanied by multiplication in its costs. The nature of the problems being experienced by the people whom we served was shifting more and more into the fields of chronic illness and away from fears of acute infection. With this came the problems of demographic change, the problems posed by the very old, and the notion that prevention was not only better than cure, it was also feasible.

Whole problem care was still possible, indeed I would believe essential, but the doctor needed to acquire a wider range of options in style and methods in order to tackle problems produced by the culture to which I have said our system of care must be responsive.

The 1965 contract had encouraged a formidable development in the organisation of delivery of patient care. The uptake of places in vocational training schemes was providing a hot-house for the growth in exploration of and research into our work as GPs. The pressures put upon the system demanded an increase in the production of doctors and the creation and expansion of undergraduate teaching. All the teaching and research opportunities afforded general practice tended to involve an emphasis on the benefits of continuity of care, of the special skills in communicating with their patients which were developed by GPs, and the particular kinds of approach to problem solving adopted by them. I must admit that I am less secure that the notion of whole problem care was fully comprehended or that the need to understand the effect of the doctor-patient relationship on communication was fully received.

What was accepted without much question but, perhaps, only with lip-service, was the notion originally conceived by Donald Crombie that GPs needed to **tolerate uncertainty** in their work. The uncertainty originates in part from the impossibility of distinguishing between the early symptoms and signs of serious disorder and the fully developed manifestations of self-limiting conditions. One approach to dealing with this uncertainty had been described as the use of time in diagnosis. Another description had been worded by Kevin Brown and me as "The specialist has to justify his diagnosis in investigation, whilst the general practitioner has to justify his investigations by his diagnoses" (10). The whole area had been summed up elegantly years ago by William Osler who wrote that a healthy patient was one who had yet to be fully investigated.

Meanwhile, small high quality video cameras became available and doctors subjected themselves to public exposure in ways which seem to me have been very different from the process of a small group discussing oral case reports. These sessions discussing videos were different also from those discussing audio tapes which always seem to be filled with background noise. A consequence of these social and professional changes was the development of an approach to learning and teaching about the consultation which, on the surface, seemed very different to the Balint group approach.

In 1984, David Pendleton and his GP colleagues from Oxfordshire published "The Consultation: an approach to learning and teaching" (11). Their approach to teaching was learner-centred and their methods sought to protect the tender shoots of professional development from overly bitter winds of change emphasising that learners should be allowed to be self-critical and that good points should be pointed out before bad ones. The rules of thumb for leaders or groups discussing video-taped consultations included: briefly clarify matters of fact; the doctor in question goes first; good points first; and make recommendations not criticisms. These rules of thumb

recommendations were important. Where possible treat your learner as you would have the learner treat patients.

Far more important than the teaching approach was the model for the content of the consultation which Pendleton and his colleagues propounded. This designated seven tasks for the GP to undertake in the consultation: define the patient's reason for attendance; consider other problems; with the patient choose an appropriate action for each problem; achieve a shared understanding of each problem; involve the patient in the management; use time and resources appropriately; and establish or maintain a relationship with the patient which helps achieve other tasks.

This abbreviated listing does little justice to the comprehensive nature of David Pendleton's contribution to our discipline. It is astounding how much we GPs owe to people who never worked in general practice, Michael Balint, Enid Balint, Margot Jeffreys, Barry Long, David Tuckett and David Pendleton to name only a few.

I want to highlight the last of Pendleton's tasks. He stipulates that he and his colleagues have worded that task, and I quote, "so that it defines a desirable doctor-patient relationship in terms of effectiveness, rather than any good, bad or less appropriate behaviour". To which statement says I, three cheers.

Let me return to what should be achieved in a consultation. In "The Future GP" my colleagues and I had emphasised that the "consultation in general practice may not be one event (the clinical interview) but a process which takes place over a number of interviews" (12). I return therefore to the notion of achieving whole problem care over a series of contracts for which the doctor-patient relationship provides the psycho-social environment and in which a GP hopes to be able to exercise power which has been personally accorded rather than authority acquired "off-the-peg" with our social role.

The 1990 contract and the current structure of the NHS has asked us to take this power and utilise it for purposes to which it may not be best adapted. Our power may not survive this abuse unless we educate ourselves.

The beginning of the NHS saw general practice in the doldrums as it went through a phase of trying to apply to self-limiting illness and problems of poverty the techniques taught in hospital as suitable for major disorder and life-threatening disease.

The result was a depressed discipline with no self-esteem.

That lack of self-esteem was treated first for some by Michael Balint and for others by the formation of the Royal College of General Practitioners. This Course and this named lecture are both evidence of present self-esteem. Treatment was continued by vocational training and we entered the age of psychosocial thinking.

As the opportunities of the 1966 Charter became manifest we entered the age of care of chronic disease. This was almost inextricably entwined with the period of opportunistic preventive medicine.

During each of these phases the doctor-patient relationship was important to both participants as they dealt with and sometimes shared the anxiety engendered by deviations from normal. With the 1990s has come the age of positive health, of health promotion and stress avoidance. The idea that what is natural must be good pervades the environment of the consulting room. We may have stopped dealing with anxiety and entered upon the task of raising it.

GPs are required now to understand a range of topics which many of us were not taught in either medical school or vocational training. We need to understand the concepts of risk, the mathematics of screening, and the health economics of trying to alter health related behaviours. To do this we need to undertake a lot of learning. We need to comprehend the nature of our patients' health beliefs and of their illness behaviours. All this is feasible, none will be easy. It will be all too easy for us to retreat behind managerial sandbags and give up to other disciplines the privileges and pleasures along with the difficulties and stresses of the carer/patient relationship.

Let me return again to what should be achieved in a consultation.

Over the eighteen years during which I was Head of General Practice at St. George's I was concerned that our research should address inter alia the matters of whole problem care, communication between GP and patient, and the effects of these themes on the patient's well-being. Having tackled history up to 1985 I will now report briefly results from some of our studies which believe illuminate these matters.

It is a natural spin off from an interest in people's behaviour and five years in small group training led by psycho-analysts that I should be interested in emotional disorder and its recognition and management in general practice. I must emphasise, however, that one does not study the doctor-patient relationship in order to become a psychiatrist manque, nor does whole problem care simply mean considering a psychiatric diagnosis concurrently with a physical one, although reaching diagnoses in both clinical fields may be the result of achieving whole problem care.

Early in my appointment at St. George's we ran a course in clinical care for local GPs on a model which would now be termed an audit group (13). One topic audited was the management of depressive illness (14). What became clear, as it does in most audits, was the huge variability among the GPs. What we knew also was that suicides attempted with tricyclic antidepressants were on the increase and that we had little in the way of antidotes to their lethal effects.

Together with my good friend Gene Paykel, now Professor of Psychiatry at Cambridge, I set out to describe what GPs did about recognising and treating depressed patients and went on to test the effects of amitriptyline against placebo in general practice

depressives. It may say something about specialists' views of general practice that the MRC chose not to fund that arm of our proposed study in which we wished to test the effects of a short-term psychotherapy, which might now be called a counselling approach, in which I had already trained a group of GPs. In the main intervention study which we did conduct we found, to our surprise, that amitriptyline was rapidly and astonishingly effective in relatively mild depressive disorder (15). In view of these findings other results became even more important than they had at first seemed. We had already demonstrated that there were remarkably few differences between recognised and unrecognised depressives in general practice, despite the fact that we used a study interview with more than 300 variables which rated patients on six schedules as well as providing opportunities for global rater impressions. Those differences which did exist made some intuitive sense. Basically, if you looked less depressed, didn't believe that being depressed made people ill, could at times respond with normal mood change, and felt somehow wrong inside but not necessarily miserable, then you might go unrecognised as depressed. There was another important component to going unrecognised which was having a concurrent physical illness making a marked contribution to your depressive illness. At this stage we had a problem. We couldn't tell whether we were dealing in truth with what it was about patients which made their depression difficult for GPs to recognise or whether we were dealing with what good recognisers do recognise and what bad recognisers do not. This distinction is of fundamental importance so we designed another study which has been conducted by Dr Andre Tylee who is now RCGP/Mental Health Foundation Senior Educational Fellow in Mental Health in General Practice in my old Department. We have stopped using the words unrecognised and recognised and went over to unacknowledged and acknowledged. This is because we were told GPs sometimes recognised depressive illness but chose not to acknowledge it. Our minimum level for a patient to have been acknowledged is for the GP to have asked the patient to return *within two weeks*. If a doctor is not at least **that** interested I do not see that it is likely that there can be benefit to the patient, who is after all our true concern.

We wished to study videos of the consultations as well as the characteristics of the patient. This study set out to collect a sample of each type of patient from each GP so that we were no longer dealing with comparing good and bad acknowledgers but those patients likely to be acknowledged with those likely not to be. We used the same exhaustive interview to compare the patients and we have two specially designed scales for rating the videos (17). There were almost no significant differences between the psychiatric and personal characteristics of the acknowledged and unacknowledged patients. On the other hand there were marked differences in the

consultations which our GPs had with those patients. For tonight's purposes I am going to focus on empathy to justify in part the huge importance I have already stated that I place on empathy, on a willingness to involve oneself in a patient's emotions, and recognising the feelings aroused in you, the doctor, without making an inhibiting response. You will remember that the same GPs provided each type of case. There was a strong association between empathy and acknowledgement and individual GPs have manifested empathy with some patients but not with others. Of course we cannot tell whether the patient was acknowledged because empathy existed or whether empathy was demonstrated when depression had been acknowledged.

A major structural change in general practice since the 1966 Charter has been the decrease in single-handed and two-doctor practices and the increase in practices with four or more doctors, with trainees, medical students, practice nurses, attached Health Authority staff, clerical and reception staff and appointment systems. A likely consequence appears to be reduction in the amount of personal care received by patients.

In 1990, George Freeman, now Professor of General Practice and Primary Care at Charing Cross/Westminster published a study of what he called personal care in four group practices (18). What he looked at was personal continuity of care which is a necessary precursor. He concluded that "This study suggests that the concept of named personal doctor with long term medical responsibility for patients must be questioned as it is one step with the reality of shared care in at least some group practices today."

A consequence of this shared care it seems to me is the possibility of producing what Michael Balint and his original GP seminar termed "the collusion of anonymity". "A collusion of anonymity", Balint wrote, "dominates the field in medicine as in education - very likely for the same reasons. The burden of responsibility is much too great in both spheres, and everyone, including the patient, naturally tries to lighten it by involving someone else, or, if possible, a number of others. This may be described as a process of dilution of responsibility. As the burden of responsibility is thus lightened all round everyone concerned is willing to enter into the collusion of anonymity" (19). One consequence of such a collusion is that the patient, too, escapes confrontation with their own responsibility for themselves.

The original collusion of anonymity related in the main to avoidance of responsibility by referral to specialists.

Nowadays it seems possible to create such a collusion and escape within the group practice itself. We have learnt to avoid dilution of our responsibilities by teaching one-to-one in undergraduate attachments and trainee years. On the other hand, I suspect we are close to completely forgetting the importance to our clinical practice of a continuing one to one relationship.

J R Army Med Corps: first published as 10.1136/jrnc-141-02-02 on 1 June 1995. Downloaded from <http://militaryhealth.bmj.com/> on January 18, 2022 by guest.

The management of an identified collusion of anonymity is to insist that only one person be responsible and that all decisions about the patient be referred to that key worker. If you place importance on fostering and comprehending a doctor patient relationship that key worker should be a doctor. Whoever becomes the key worker will need support from a small group, at least in the first instance. It is by means of small group support that one can learn to tolerate such responsibility without either provoking avoidance behaviour in the doctor, or causing practitioner burn out. A primary care team might be able to act as such a support group.

I believe that GPs should try to continue to provide individuals with whole person care applying concepts which derive from public health. It must be remembered that in public health medicine the well being of individuals is often treated as secondary to that of the groups to which they belong. We have a great deal more to learn if we are to produce good quality personal public health without destroying the personal doctor who provides whole problem care. I am hopeful that you Service trainers are willing to undertake the learning and to share in the teaching.

I am committed to retaining and riding my hobby horse, that the prime task of general practitioners is to foster an appropriate doctor patient relationship and to provide whole problem care. My students were taught about these concepts and how they are an essential component of any civilised system of health care. I believe of course that provision of that care is the function of general practitioners and not of their employees.

I would like to think that the spirit of Sir David Bruce would stand beside us as we endeavour to deal with the new age which will still be packed with the old troubles. I certainly hope he would approve of what I have said to you tonight. I have evidence that he might. I have a bibliography of Sir David's work between 1887 and 1924 compiled by the librarian at this college. The bibliography lists 172 items. Number 169 is Sir David's Inaugural Address as President of the British Association. Its title is Prevention of Disease and it bears reading today. I will quote from the last paragraph of its 14 pages (20). "Mankind," says Sir David. "Is still groaning and travailing under a grievous burden and weight of pain, sickness and disease. Interruptions are sure to come in the future as they have in the past in the work of removing the incubus, but in spite of these, it is the duty of science to go steadily forward, illuminating the dark places in hope of happier times."

Let Sir David have the last word.

REFERENCES

1. Anonymous (Editorial). *Br Med J* 1984; 427.
2. "Observations on Malta Fever". *Br Med J* 1989 **1**:1101.

3. SPENCE J. The need for understanding the individual as part of the training and function of doctors and nurses. In: *The Purpose and Practice of Medicine*. London: Oxford University Press, 1960: 271-280.
4. THOMPSON WAR. In :Foreword, *The Doctor Patient Relationship*. Edinburgh: Churchill Livingstone, 1967.
5. BROWNE K, FREELING P. The special function of the general practitioner. *Lancet* 1964 **i**: 425-427.
6. BROWNE K, FREELING P. An introduction to the discipline in *The Doctor Patient Relationship*. 2nd ed. Edinburgh: Churchill, 1976: 1-7.
- 6a. BROWNE K, FREELING P. Communication and language in *The Doctor Patient Relationship*, 2nd ed. Edinburgh: Churchill, 1976: 31-37.
7. SZASZ T, HOLLENDER M. A contribution to the philosophy of medicine: the basic models of the doctor-patient relationship. *Arch Intern Med* 1956: **97**:585.
8. FREIDSON E. *Professions of Medicine*. New York: Dodds Mead and Co, 1970: 317-8.
9. BYRNE P, LONG BEL. *Doctors Talking to Patients*. London: HMSO, 1976.
10. BROWNE K, FREELING P. *The Doctor Patient Relationship*, 2nd Ed. Edinburgh: Churchill Livingstone, 1976: 9.
11. PENDLETON D. *et al.* *The Consultation: an approach to learning and teaching*. Oxford: University Press.
12. The Royal College of General Practitioners. *The Future of General Practitioner: Learning and Teaching*. London: British Medical Journal, 1972.
13. FREELING P, BURTON RH. General practitioners and learning by audit. *J R Coll General Pract* 1982; **32**:231-237.
14. BURTON RH, FREELING P. How general practitioners manage depressive illness: developing a method of audit. *J R Coll General Pract* 1982: **32**:558-561.
15. HOLLYMAN JA, FREELING P, PAYKEL ES, BHAT A, SEDWICK P. Double-blind placebo-controlled trial of amitriptyline among depressed patients in general practice. *J R Coll General Pract* 1988: **38**:393-397.
16. FREELING P, RAO BM, PAYKEL ES, SIRELING LI, BURTON RH. Unrecognised depression in general practice. *Br Med J* 1985; **290**:1880-1883.
17. TYLEE AT, FREELING P, KERRY S. Why do general practitioners recognise major depression in one woman patient yet miss it in another? *Br J Gen Pract* 1993: **43**:327-330.
18. FREEMAN GK, RICHARDS SC. How much personal care in four group practices? *Br Med J* 1990: **301**:1028-1030.
19. BALINT M. *The Doctor, his Patient and the Illness*. 2nd ed. London: Pitman Medical, 1964: 93.
20. BRUCE D. Prevention of disease. *Nature* 1924: **114** (Suppl): 213-227.