Medicine in the 'Seventies

New kinds of doctors

An interview with Dr Julian Tudor Hart

FROM A SPECIAL CORRESPONDENT

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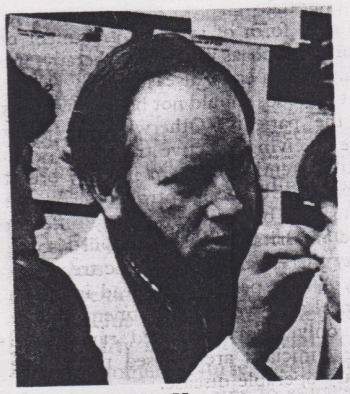
"If we are serious about making substantial changes in the content of medicine and the work we do," said Dr Julian Tudor Hart, "we've got to be serious about finding a new type of student and producing a new kind of doctor." Approaching 50 years old, a general practitioner in a small village community a few miles up the valley from Port Talbot in South Wales, he believed the most that could be asked of his generation was that they should be receptive to ideas of change, and in particular to a massive shift of emphasis to the primary and secondary prevention of disease.



Dr Julian Tudor Hart

"We should help our students to become doctors of a quite different kind from their teachers," he continued. "As a first step we should take a critical mass—20% or so—of mature students with 2 or 3 years of real experience of other work—not something they have read in a book but ideas of their own about how the health service works." Part of the education of the new doctor would, he thought, be his preparation to be a leader and an educator in the community. It was not the doctor's job to do everything, but it was his job to be the person most enthusiastic and knowledgeable about health in the community.

Medicine and education

Making changes in a nation's health was, he believed, analogous to education. Education should not be a prerogative of teachers alone: it should bring in the whole population, and if the whole population did not want an education, if it did not think education important, or saw it as important only for personal acquisitiveness and social position, then the teachers would not be able to achieve real change. In the same way, doctors could not work effectively without a community that was health conscious (not health acquisitive). "In North America health consciousness has become egotistical," Dr Hart went on. "It has become a market commodity that is bought and sold. Here we have an opportunity to set a real value on health."

Community paediatrics and prevention

For example, a paediatrician's job should not be confined to providing emergency and salvage care for children who become ill—very few children should be unhealthy. The paediatrician should, he believed, have responsibility for the continued education of all the primary care doctors in his catchment area, seeing to it that they were aware of new developments in paediatrics. He should spend as much time out of his hospital as in it, supervising his extended outpatient department. He should be planning the health education and prevention programmes and thinking about what could be done in childhood to prevent adult coronary disease, stroke, or diabetes. What was needed was to concern both doctors and medical teachers in an anticipatory, continuous style of preventive work rather than the discontinuous, sympto-response, emergency type of work that had always carried the kudos in medicine.

Primary prevention could be enormously exciting—but it had to be specific: not any community, but one's own community, not any people but the actual people within that community itself. "We had a rubella-damaged child born here about 13 years ago, a sixth unwanted child. The mother had had no symptoms of rubella at all but the baby was born with cataracts and turned out to have brain damage. The family continued to live here for 11 years (they have now moved) and the child was a living demonstration to the whole village of the importance of preventing rubella damage.

We used his example: we had a backup programme for the school rubella vaccination programme designed to catch the girls who weren't vaccinated at school. We wrote to the medical officer of health for a list of the girls who hadn't been done. "We can't let you have that list," he replied "our list is of the vaccinated girls." What use is a list of vaccinated girls? It is the list of those who need vaccination that is important. In fact we worked out the list for ourselves. That awful situation had drained so much of my energy—the whole family living in a house with cardboard over all the windows because the panes had been knocked out by this child—and yet it provided the whole community with a lesson. And, indeed, we used the example of this child as motivation for the patients (and for ourselves) and we have been able to secure virtually 100% vaccination. In the same way, we use grandparents' memories of diphtheria to ensure 100% diphtheria immunisation.

However, in this context he was opposed to suggestions that blood pressure machines should be set up in chemists' shops and supermarkets. That might solve the simpler part of a hypertension screening programme—in a haphazard way—but it might destroy any chance of solving the real problem: continued follow-up. "I don't believe that most doctors will warm to a patient who walks in and explains that he took his blood pressure in the supermarket and found it was diastolic 120." Some simple things could be farmed out into the community; patients could do a lot for themselves; but the doctor had to lead a team that carried responsibility for the health of the community it served.

City problems

Was this close identification of the doctor with the community possible in city boroughs or in inner London? Dr Hart agreed