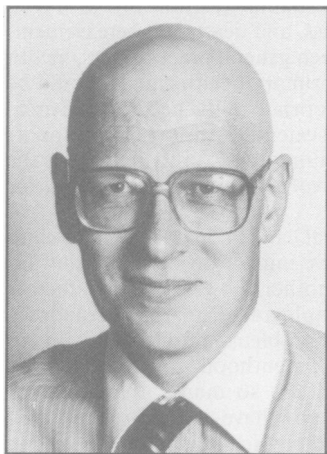


# Quality of caring — landscapes and curtains

JOHN G.R. HOWIE, MD, PhD, MRCPE, FRCGP



John Howie

THE honour of being invited to deliver the James Mackenzie Lecture falls to few. The occasion is properly regarded both within general practice and beyond as an important event in the academic calendar, and I am deeply conscious of the responsibilities as well as the opportunities it brings.

Many of my predecessors have mentioned the pleasure they have had from re-reading past lectures during the preparation of their own manuscripts, and I can echo this. Several common denominators can be detected. In one way or another the lectures are all placed in the context of the contribution James Mackenzie made to the thinking about and practice of clinical medicine. They all touch on a theme or issue of importance to the discipline of contemporary general practice. And they all reflect the personal interests and philosophy of the lecturers as surely as if they were fingerprints of professional life and style. This is a tradition I will try to continue.

James Mackenzie, I will invoke towards the end of my lecture. My contemporary theme can be no other than that of 'quality of care', because, of course, improving it is — or should be — the invariable target of all who are involved in the broad work of the caring professions. 'Quality of care' has never been a more topical theme but it is also a concept in difficulty, too easily a platitude at the institutional level rather than something which compels effectively at the personal level. I will try to comment constructively on why this may be and how a small change in emphasis might prove helpful. The setting for my lecture is research. Not research as an end in itself, but research as a way of thinking as it contributes to the 'ends' of better care for patients, the personal and professional development of doctors as individuals, and the evolution of the profession we are proud to belong to.

In presenting my lecture I must confess to self-indulgence. I want to present three research cameos, two from my own past and one in the present. I see in them unexpected common denominators which I believe are conceptually helpful to my later

comment about quality of care. I hope at the same time that the material from these research cameos will in its own right be of sufficient interest and variety to maintain the balance between information and ideas that my predecessors have aimed to achieve.

## Looking backwards

### *The first cameo — the appendix and abdominal pain*

Perhaps I became a doctor because I had my appendix out while undecided on what to do when I left school; possibly I became involved in academic medicine because my childhood and upbringing taught me to think of cold weather not in degrees Fahrenheit but in terms of wind speed and relative humidity. Almost certainly my first research interest became the pathology of the appendix and its relation to abdominal pain because first as a student and then as a house surgeon, I realized that the correlation between preoperative diagnosis and operative findings was by no means high and indeed was rarely discussed postoperatively with anything approaching academic candour. During what was intended originally to be a single postregistration year in pathology, I quickly became fascinated by the surprising difficulty of separating normal and abnormal appendices on histological grounds and thus began four years of researches which were to prove to be my vocational training for the life I have led since.

I want to describe three separate excerpts from my 'appendicitis' days. The significance of my choices will become clearer later.

*Recurrent abdominal pain.* Probably the greatest difficulty the clinical pathologist has had to face in the appendix field is making histological sense of the cluster of conditions variously known as 'the grumbling appendix', 'chronic appendicitis', 'recurrent appendicitis' and 'mesenteric adenitis'. In truth, there are no adequately researched histological grounds for making any of these diagnoses and the high probability that appendicectomy will coincide with cure does not help scientific exploration of the problem.

The truly normal appendix is a rare histological finding and a degree of fibrosis and fatty change in the submucosa (usually attributed to previous inflammation) is an almost invariable finding in appendices removed either because of possible appendicitis or at unrelated abdominal surgery. While looking at a haematoxylin and eosin stained section from a resolving appendix abscess, I noted some deposits of iron in the organizing inflammatory mass and was astonished at the extensive amount of additional iron that became evident when the same section was specifically stained for iron deposits using the Prussian blue reaction (Figure 1). It was exciting to find that the presence of stainable iron in fact correlated well with recent symptoms suggestive of appendicitis;<sup>1</sup> and particularly rewarding to find that the presence or absence of stainable iron allowed, among other things, differentiation of patients with mesenteric adenitis into two roughly equal groups, one of 25 patients with iron-positive appendices whose cure rates following appendicectomy was virtually 100% and a second group of 15 where there was no iron and symptoms recurred within two years of appendicectomy in some 40% of patients.<sup>2</sup>

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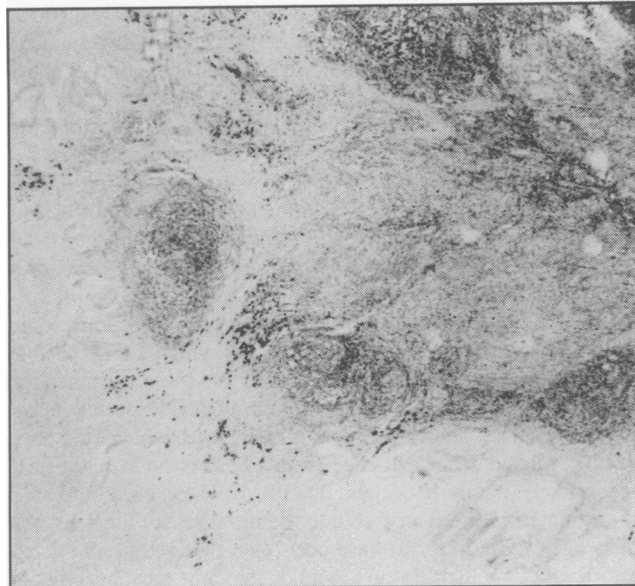


Figure 1. Cross-section of appendix stained for iron-deposits (magnification  $\times 100$ ). History of recent appendix abscess.

**Family trends.** The second excerpt is an extension from the histological studies of the appendix of which the study of iron was a part. It now became possible to compare family patterns of appendectomy in patients whose appendices could be more accurately classified as abnormal and normal. It was found that 19% of the 874 parents and siblings of 204 females aged 12–29 years having normal appendices removed for acute abdominal pain had had an appendectomy in the past. The matching figure for the control group based on 204 females whose appendices did show acute appendicitis was 13% of the 825 patients and siblings. The figure for the parents and siblings of the 92 males in both categories was also 13%. The conclusion, maybe not particularly surprising, is that appendectomy seems to run in families but appendicitis does not.<sup>3</sup> Others have written about why this might be so.<sup>4,5</sup>

**Cancer and appendectomy.** My third excerpt takes me to 1964, the date of a scare that previous appendectomy might predispose to later development of malignant disease, not only in the bowel but elsewhere and particularly in lymphatic tissue.<sup>6</sup> If this were true there were far-reaching immunological implications. The human appendix is the analogue of the bursa of Fabricius in the cock — the regulator of the cock's immune systems. My then professor was a distinguished immunologist and I was detailed to check this observation. The index study proved to be flawed in an interesting way. In Figure 2 it can be seen that the cancer patients were drawn from autopsies performed between 1947 and 1962; the controls died almost exclusively between 1951 and 1955, with an additional group dying in 1961. Although age of cancer and control patients was matched and the mean year of death was the same for the two groups, 60% of cancer patients and 30% of control patients came to autopsy in the second half of the time studied. Projecting back to when appendectomy would have been carried out, it becomes evident that many more of the cancer patients had been adolescents after the start of the 'appendectomy' era than was the case for the control patients; improper matching had resulted in unsafe findings. Fortunately our own prospective Scottish study failed to find evidence of association between cancer and appendectomy,<sup>7</sup> and others later confirmed our findings.

### *The second cameo — respiratory illness and antibiotic use*

On the first day of October 1966 — the day of the Charter — I became a principal for the first time, joining a single-handed doctor in a Glasgow city practice. Within six months, we had become a group of three and I set about learning my job by watching my two seniors at work, each of whom had learned his craft from separate mentors. In many things they did they were different; but in important things there were common denominators. In particular, they knew who was ill, they had their coping strategies well practised and their patients believed in them. For me the problem was making explicit exactly what they did, and where and why it was sometimes the same and sometimes different. There were no general practice atlases or recipe books around, and the vocabulary of pathology and the language of inpatient medicine were imperfect, but to that dangerous degree only apparent when the problems created by their use begin to be thought through. The use of antibiotics for respiratory illness became the focus of both my interest and confusion. The width of difference between doctors in their prescribing of these drugs was then — and I regret still is — seen by some as a sign of the survival of clinical freedom and of the virility of the independent contractor status, but for me the extent of that width has always been an embarrassment when defending general practice as a credible discipline — whether clinically or intellectually.

**Diagnostic labels.** In this cameo, the equivalent of the use of the Prussian blue reaction in trying to unravel the story of the appendix and its relation to abdominal pain, was the now obvious truth that diagnostic labels are often (but, of course, not always) rationalizations rather than determinants of decisions, and that researches based on their use may obscure rather than enlighten.<sup>8,9</sup> I state that here to keep my later arguments tidy but will not develop it further nor, on this occasion, illustrate it with examples.

**Psychotropics and antibiotics.** There is, of course, now an extensive literature about the use of antibiotics in general practice. Some of it is descriptive, some is more analytical and some is based on clinical trials.

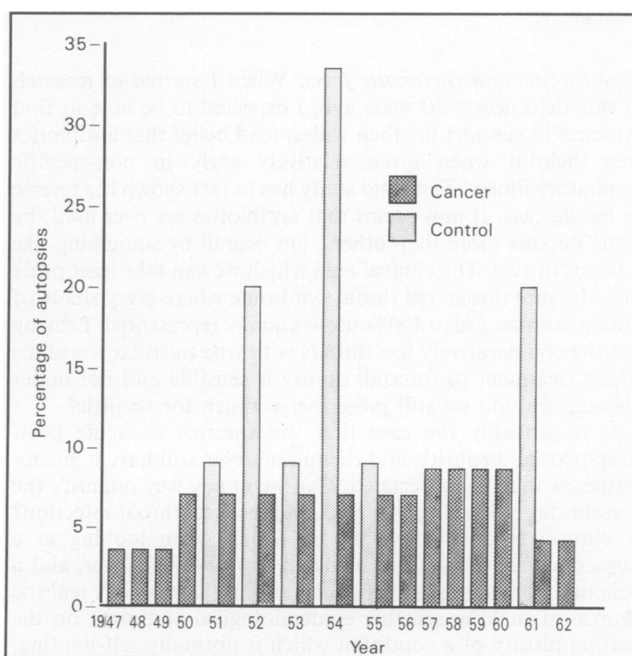
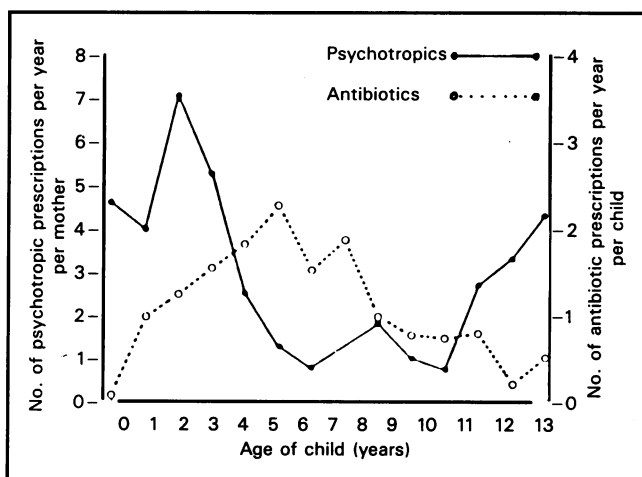


Figure 2. Percentage of total 'cancer of colon' and control autopsies carried out each year in study reported by McVay.<sup>6</sup>

For the second part of this came I want to refer to only one piece of work. Although the study itself will be familiar to many, I make no apology for talking about it again as the principles it opens up are central to our discipline. The study, involving 50 consecutive families from an Aberdeen practice using mothers in their forties as index patients, showed a strong association between high psychotropic prescribing to mothers and high antibiotic prescribing to their children.<sup>10</sup> The age distribution of the children when they received antibiotics was as expected, but the pattern of psychotropic prescribing in the mothers provided what was almost a mirror image. The two distributions together (Figure 3) encapsulate as well as words ever could how enormous is the challenge of making our discipline measurable while keeping its practise sensitive to the infinitely complex interweaving of the physical and psychosocial components of illness and health. In particular we must remain mindful of the wide and wholly legitimate differences which can be found in how patients and doctors may interpret and manage similar situations.



**Figure 3.** Rate of prescribing psychotropic drugs to mothers classed as high users of these drugs and rate of prescribing antibiotics for acute respiratory illness to their children by the age of their children.<sup>10</sup>

**Sore throats and rheumatic fever.** When I started to research in this field nearly 20 years ago, I expected to be able to find evidence to support the then widespread belief that antibiotics were helpful when given relatively early in non-specific respiratory illness. Time and study has in fact shown the reverse to be the case. It now seems that antibiotics are over-used, by some doctors more than others, but overall by something like a factor of two. The clinical area which we can take least pride in is the sore throat/red throat syndrome where every shade of policy from no use to 100% use is equally represented. Leaving out the comparatively few throats with true pustular tonsillitis where treatment to forestall quinsy is sensible and not under dispute, why do we still prescribe so much for so little?

It is probably the case that the spectres of acute post-streptococcal nephritis and rheumatic fever still have a greater influence than is appreciated. Can we in any way quantify the present-day risks of non-treated streptococcal throat infection? If clinical epidemiology can go wrong when looking at a numerator as well defined as death from bowel cancer, and a denominator as simple as appendectomy, have we any realistic chance of making sensible epidemiological comment on the natural history of a condition which is normally self-limiting, is often self-treated by patients and is normally diagnosed on clinical grounds which are well known to be no better than about

30% accurate? We can either say the task is impossibly difficult or we can make a best-possible attempt using the information available cautiously and honestly. I believe the second of these choices should normally be our aim, although it is both irresponsible and inappropriate to make such attempts without making sure all the proper groundwork has been undertaken first.

To complete this part of my lecture I present only a few figures to emphasize both what can be done and how difficult it is to draw firm conclusions. From all one million children aged 0–13 years in Scotland, there were 19 cases of confirmed post-sore-throat post-streptococcal rheumatic fever seen in hospital during the four years 1976–79. Using a number of projections, some of which are safer than others, but all of which are defensible from published literature, it was assumed that these 19 numerator cases came from a denominator of about 660 000 streptococcal illnesses — itself an estimate that is in line with what could have been predicted from evidence from elsewhere. On balance it seems likely that more of these illnesses will have been untreated than treated, although of course the more severe illnesses will have been more likely to have been seen by doctors and given antibiotics — which, in turn may or may not have been taken as directed. Approximate comparative risks can be estimated.

Risk of developing rheumatic fever after streptococcal sore throat:

Treated with antibiotic	$\frac{9}{264\ 000}$	= 1:30 000 (approx.)
Untreated	$\frac{10}{396\ 000}$	= 1:40 000 (approx.)

It is helpful and reasonable to discuss these estimates and to base broad policy statements on them.<sup>11</sup>

It would be a distraction from what I am arguing today to debate this issue in detail. But, in making the case that our discipline must aim steadily towards being able to base policies on the best available clinical epidemiology, it is reasonable to ask you to note how few patients now develop the index condition we worry about, to note that both 'treated' and 'untreated' patients have developed it, and to see that the risk is exceptionally low whatever way the denominator is calculated. Indeed, penicillin allergy is a commoner risk and possibly a more serious one.

In the first half of this lecture I have been looking backwards. Backwards at research aiming to improve the care of patients with abdominal pain who might have appendicitis; and at research aiming to make the care of patients with respiratory illness more perceptive and rational. At the time, each of these projects was about the here and now and the findings were principally intended to be clinically useful in their own right.

Increasingly I now look at these researches not for the short-term information they have provided but for the principles which they teach in common and which will be of longer-term and wider value. There are three I want to mention as markers for the second part of this lecture:

- First, the activities we undertake — research on this occasion, but clinical care, teaching, politics on others — are nearly always helped by a willingness to look beyond textbooks and the perceived wisdom of the day. Feelings, whether these be hunches or beliefs, or judgements or tactical assessments, are a necessary and proper part of the making of balanced and effective professional decisions.

- Secondly, medicine is strongly about people as well as pathology and these people can be patients or they can be doctors. Once again all our professional activities must respect this key reality which applies to medicine in hospital as well as in general practice albeit in necessarily different proportions.
- Thirdly, the lessons to be drawn from using the thinking, skills and findings of clinical epidemiology are as important to general practice and general practitioners as they are to workers in any other field of medicine. And, what is more, they are as difficult to apply as they are important to value.

For the second half of my presentation I am going to turn to the issue of 'quality of care' and will look at the present and to the future more than to the past.

### Looking forwards

#### *Quality of care*

At this point I want to comment briefly on the green paper on primary care which is presently the subject of active professional and political discussion.<sup>12</sup> My comments prepared at one moment of a rapidly moving and sometimes rather polarized debate are necessarily about generalities rather than details. In any activity where the public relates to a professional group with the state as a pivot between them, it is likely and proper that balance of priority or purpose will occasionally benefit from being reviewed. In 1966 the profession initiated such a review; in 1986 the public through government is asking for discussions. The public are entitled to ask for averaging up rather than down and the profession wants this too. The state is right to be anxious at the possible implications of an open-ended budget and the green paper correctly states that costs correlate more closely with numbers of doctors in the system than with the numbers of patients being looked after. The green paper<sup>12</sup> has, nonetheless, accepted three significant points put forward by the profession: primary care services cannot be cost-limited; the independent contractor status of general practitioners should be allowed to continue to evolve; and the profession should have first opportunity to deliver on the subject of control of standards of services.

Difficulties begin when the concepts of quality and standards come to be examined. Standards can be minima, averages or targets. Quality is an abstract attribute which although likely to correlate with many measurable features — those proposed in the green paper are mainly of practice organization — will not be guaranteed by their presence or necessarily missing in their absence. There has been little support for the 'good practice allowance' as originally offered, and I go along with that insofar as I do not believe it would be a direct measure of goodness and also doubt that we yet have a mechanism for delivering fair assessments of who deserves it. However, I think we must accept the invitation to discuss the thinking behind it; the opportunity to define and fund 'good practice structure' in terms of an altogether better resourced and staffed 'team', and in terms of the necessary support for the management of a modern practice should not be missed. At the same time, the government must recognize that the concept of a higher capitation element to payment appears a step backwards to the pre-Charter days which there seems little public or professional wish to revisit.

However, the key issue in the quality debate is surely list size; and this in turn is a substitute for the issue that underlies it — namely the wish of both doctors and patients that consultations should not only last longer but also appear to be freed from

the pressures of time that so distort the provision of sensible, sensitive and satisfying care.

The authors of the green paper state that 'there is at present little evidence of a direct link between list size and the quality of care, and consequently little to indicate what might be the optimum list size'.<sup>12</sup> It is a sad commentary on our discipline, that we have to accept that as a correct assessment of the present state of knowledge about our art. A number of major pieces of research have tried to throw light on these issues of list size, time with patients and quality of care given. Buchan and Richardson<sup>13</sup> have observed a large series of consultations and shown that these can be analysed for content — but not easily interpreted for quality. Butler<sup>14</sup> has noted that doctors with smaller lists booked patients at longer intervals and were more available to their patients. Wilkin and Metcalfe<sup>15</sup> have found a few associations between list size and time spent with patients in the hoped-for direction, Morrell and his team<sup>16</sup> have found that some alterations in consulting patterns occurred when patients were given longer appointments, and Fleming and colleagues<sup>17</sup> have done work which suggests that more preventive work takes place in practices with smaller lists although, of course, it is difficult to know whether or not such associations have a simple causal relationship.

Have these studies been unable to answer the list-size/quality question conclusively because the relationship does not exist? I doubt it. Two other causes seem more likely: the first that these studies have used outcome or process measures which were either too crude or too complex and the second that one or more important intervening variable has been present but not adequately catered for.

#### *The third cameo — stress and doctoring*

My third cameo is in the here and now and cannot be presented as neatly as my previous two because ideas, methods and results are in the untidy relationship to each other that reflects the realities of a developing research interest. However, once again I want to identify feelings and beliefs as the starting point for change; I will again emphasize the centrality of people in the process of defining goodness of medical practice; and at this stage I can do no more than hint at the complexity of the clinical epidemiology required to take our researches to the stage where they will answer as many questions as they raise.

*The problem.* In a consultation, a patient with a problem meets a doctor trained to respond to it. In the good consultation the problem is defined, its meaning discussed and a plan of action agreed after an interaction in which the understandings, beliefs and values of both participants make their contribution. Probably the average consulting session is now booked for eight appointments in the working hour. But many doctors still work the 24 patients in two hours system. This arrangement produces beguilingly satisfactory outcomes. To use the analogy of diving competitions, these are low-tariff consultations; little is expected, little is attempted beyond processing of the presenting complaint, and satisfaction is high because expectation was low. With longer consultations — and the six patients per hour model seems an attractive target — the tariffs are high, or at least higher. Risks are taken by both doctor and patient. Significant gains may result from difficult areas being tackled. Short-term ambivalence which patients may feel about what has gone on in the consulting room will often turn into long-term appreciation of the benefits which follow. Results are as difficult to evaluate as the consultations may have been for either or both participants.

Education is attempting to ensure that today's doctors understand what are the risks, costs and gains of different approaches to general practice work and that they have the skills appropriate to personal and continuing care of families; research has still to identify what factors determine why and when high-tariff doctors will go for low-tariff options, and what determines whether high-tariff consultations will succeed. For me, this is in simple terms the central issue of the quality debate.

At face value list size seems likely to be a variable that will be important. But I believe there are more important related variables. These add to create the attribute of stress or pressure. Of course, some stress or pressure is an aid to effective performance. It has to be expected in any profession undertaking responsible work, and should not be regarded either as unique to general practitioners or as unhealthy. But all too easily, a combination of work stresses such as overload, repetition, uncertainty about role and fatigue, can link with, for example, outside commitments and personal and family worries, to create the ambience in which good practice is put at risk. Stresses in turn are modified by complex coping strategies which include prescribing, referral, rejection, speeding up and slowing down, and are moderated by experience and by personality as well as by training.

Our hypothesis is that provision of the environment in which goodness of care will occur can be helped by good structure or organization; but that the fulfilment of its potential depends on the doctor then being as free from discomforting distractors or stresses as is possible.

*The work.* We have started tackling this hugely difficult but most challenging and important of themes first by trying to see if we can measure the stress doctors feel themselves under, and secondly by looking at the pattern of their working arrangements and their personal and professional commitments. We are about to add information on the clinical decisions that they make. At all stages we expect to use the doctors as their own controls.

The work is at an early stage but a few illustrations will give a flavour of what we are trying to do. Using a timing device which the doctors have not found intrusive, we are using a half-hourly self-report measure of stress over the working day. The scale runs from 0 to 6 and, by our definition, at levels of 4 and above stress is becoming uncomfortable. Figure 4 gives three examples of the patterns we are finding. Our measure has good

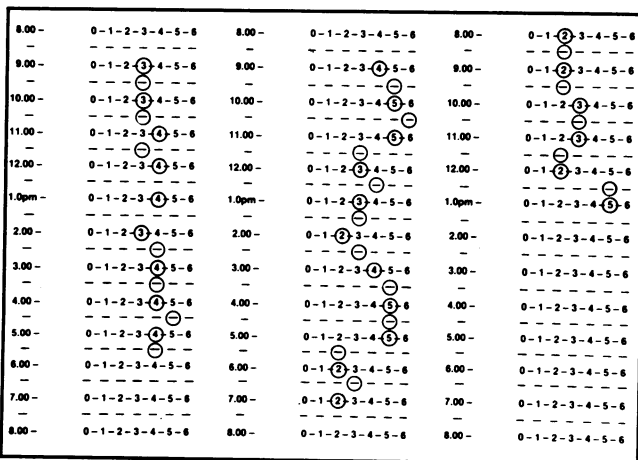


Figure 4. Self-recording of stress by doctors on relaxed (0) – tense (6) scale with 3 regarded as optimal. The left-hand entry represents an average working day and the centre entry a 'difficult' working day. The right hand entry is after a night on-call, with a half-day expected and a pre-lunch problem arranging hospital admission for an elderly patient. (See also reference 18.)

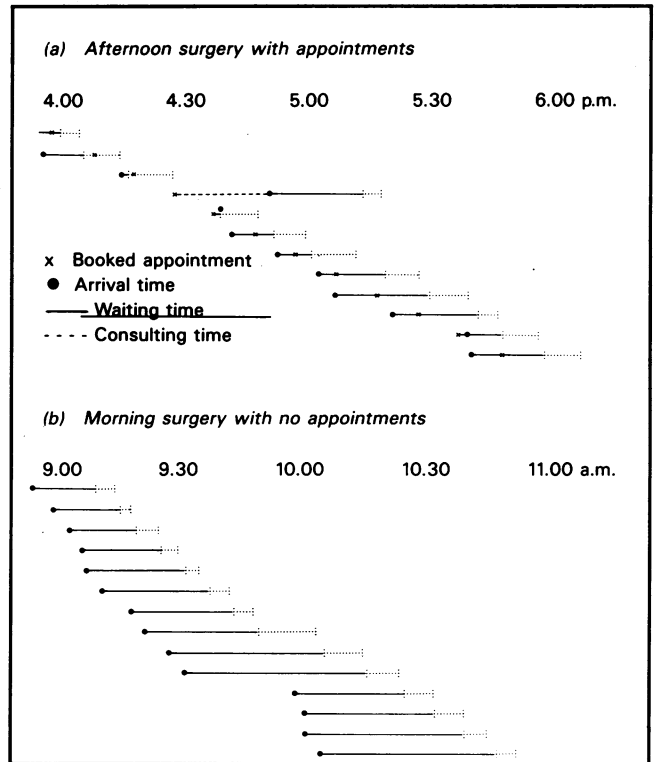


Figure 5. (a) Flow diagram of patients through an afternoon surgery (4.00-6.00 pm) with appointments – the fourth patient arrived late, average waiting time was 12.6 minutes of which 8.2 minutes was after the booked time, average consultation lasted 8.2 minutes. (b) Flow diagram of patients through a morning surgery (9.00-10.00 am) with no appointments – average waiting time was 27.9 minutes, average consulting time was 5.3 minutes.

face-validity and, in the format we are now using, correlates well ( $r=0.9$ ) with the 'stress adjective check list', the only validated instrument available for us to check ours against.<sup>19</sup>

From a still very small study we would be wrong to draw firm conclusions, but the practice with routine 10-minute consultations has 15% of its readings at 4 or more compared with 30% at 4 or more in the practice which works at eight patients per hour and has half its sessions without appointments.<sup>18</sup> Would a 12-patients-per-hour practice be more stressful still – or might it be the least stressful of all, for the reasons I have just discussed?

Using a series of work-flow timings we have also succeeded in mapping patient flow through surgeries in a way which looks as if it could be used on a relatively large scale. Two examples (Figure 5) contrast the patient waiting times and the consultation durations in a booked and an unbooked surgery.

It needs little imagination to try to fit these two research tools together. Until we can do something like this and put it in the context of the problems patients present, the team and its proper development, the clinical decisions which are taken and the satisfaction of all parties with these, we can do no more than guess at how primary care services really ought to develop. In fairness our guesses are not blind and they are being made in good faith, but I wonder if we do yet know enough about good practice to justify embarking on a major reconstruction of a system which still seems to be evolving purposefully. What is certain, is that we will do ourselves no good by declining to discuss the issues constructively with the government, who fund our activities, and with our patients who, by and large, still respect us and value what we do.

### Landscapes and curtains

I have two tasks still to fulfil. The first is to explain my title and draw together the ideas I have introduced in this lecture; the second is to return to Sir James Mackenzie.

I expressed a neutrality about the term 'quality of care' at the start of this lecture. It is difficult to be sure why. I wonder if it is because it seems third-person passive and abstract. For me, the phrase 'quality of caring' changes the emphasis in a way that seems helpful. The voice then seems to be talking more about people than things; the mood seems to become active; and the tense is then present and continuing. It may still be abstract, but it feels like something to become involved in rather than something to suspect as elitist. 'Quality of care' has got into difficulty because, despite the promise of the *What sort of doctor?*<sup>20</sup> thinking, quality is still largely being identified with structure. Good structure is probably an important part of quality but something more is needed.

About a year ago I had the pleasure of reading John Berger's *A fortunate man*,<sup>21</sup> the immensely moving and sympathetic story of the life of a country doctor. The first two pages are an open sketch of a rural scene, probably English, but with the hint of starkness more identified with the Highlands of Scotland. There is a cottage, a hill, a field, some trees, a river; and a boat with a fisherman and his son rowing to shore as dusk falls. These are four lines of text:

'Landscapes can be deceptive.

Sometimes a landscape seems to be less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place.'

What a wonderfully apt way of describing the challenge, the reward and the feeling of being a family doctor.

This lecture has been about landscapes at one level, but in reality about seeing behind the curtains they represent. My three cameos were landscapes. Behind the curtains of 'the appendix and abdominal pain' and 'respiratory illness and antibiotics' were messages that were also applicable to the third cameo about 'stress and doctoring'.

'Quality of caring' is a landscape too. And the same messages are there again. Feelings can be important guides towards making good empathetic professional decisions; the right balance has to be found between focus on patients and on their pathology; and there is an obligation on us all to think critically and to respond thoughtfully to what we find when we do.

In general practice we have often been properly sceptical of research and researchers because ground rules were adapted from other disciplines and were either unsuitable or even misleading when applied to our field. As our confidence in our own discipline has grown and now that better methods of enquiry are being more sensitively applied, the essential contribution of research to the thinking about and practice of our discipline is being more generally appreciated and accepted.

I have already urged that we do take part in serious discussions about the 'structure' of our services with those who fund them and receive them. It is a matter of real regret that these discussions must take place without adequately researched evidence for their proper resolution. The fault lies partly in past underinvestment in research and development by both the state and the profession. But it is also partly the consequence of the anti-intellectualism which has for so long haunted our discipline and restricted its capacity to fulfil its potential.

I do not think it is going too far to suggest that it is because of this all too visible reluctance to question, to evaluate, and to respond that our claims to 'clinical freedom' are so often questioned from outside. Clinical freedom is not a right. It is a responsibility we earn; and earn partly for how we organize

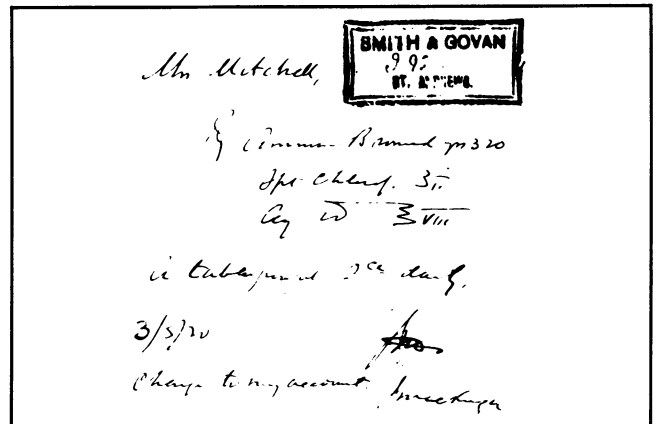


Figure 6. Prescription written by Sir James Mackenzie in May 1920.

ourselves, partly for the way we serve our community, and partly for our commitment to being critical of what we ourselves are about.

If today's Mackenzie lecture has an epilogue, let it be that it marks the day when we finally discard the outdated stereotypes and prejudices that have kept the activities of patient care and of research apart when instead they should be firmly integrated and accepted as being as wholly interdependent on each other as they in fact are.

### James Mackenzie

It is difficult to say anything truly new about Mackenzie, the man we honour today. He was an outstanding general practitioner by any standards and his 28 years as a family doctor in Burnley (which commenced only a term after graduation and without the benefit of approved vocational training) were combined with the early researches into heart disease for which he became internationally known. He had a second career as a cardiologist, and in the closing years of his life founded the Institute of Clinical Research in St Andrews.

His obituary describes him as 'kindly in disposition and always approachable, though sometimes almost brusque in manner'.<sup>22</sup> It talks of him as a visionary and about his prophetic role in medical affairs. He indeed was certainly right, for example, when he wrote that medical teaching should start with the simple and that the complex then became easy; and his belief of the importance of the general practice contribution to research, and of the values of research thinking to general practice and general practitioners are themes I have returned to more than once in this lecture.

It is a matter of pride for me to be able to trace my ancestry back to the great man. Although I am not good at family trees, I am reliably informed that my grandmother was a cousin of Mackenzie. My last illustration (Figure 6) gives some support to my claims. In 1920, five years before Sir James died, and after he had returned to work as a general practitioner/cardiologist in St Andrews, my grandmother consulted him in his rooms and received this prescription, which has miraculously survived the passage of time and passed to me as a family heirloom.

This is a fitting place for me to stop. This prescription is my last landscape. In it I see caring and I see general practice; I see the family; and I see St Andrews — standing as it does for Mackenzie's beliefs in and commitment to the values of critical thinking and enquiry.



When Sir James wrote this prescription now more than 66 years ago, I would like to think that he would have approved of the rather different use that was to be made of it today on the occasion of this thirty-third lecture in his memory.

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