INTERVIEW WITH DR. JOHN HORDER
Date: FEBRUARY 4, 1995
INTERVIEWER: DR. FITZHUGH MULLAN

MULLAN: Today is the fourth of February. I am with Dr. John Horder in his house in Regents Park, London. We're going to chat a little bit about his background. In these interviews what I like to do is ask about your background, starting with your personal story before medicine, a little bit about how you grew up and how you got interested in medicine. Then, after that, talk a little bit more about medicine. So where did it all begin?

HORDER: My medical story starts very late, compared to many people, but my background is that I was brought up in London, the third child, much younger than my two sisters. Born in 1919, just after the first world war, which was a very terrible period for this country.

My grandfather was a Nonconformist Minister. He's a very important character in my life, despite that I never met him. I'm writing something about my own life at the moment. He is the starting point of this. His influence came through his six or seven children. My parents were over forty when I was born, and I was surrounded by very serious, idealistic, unworldly people, who were very strong. Counting my two sisters and four unmarried aunts living near, I often think that I had seven mothers.

Rather strangely, I was sent to an Anglo-Catholic religious school, where we went to church twice every day. So the religious

and ethical background of my childhood was very strong. Although I now see that I did'nt really accept some of it even then, I've certainly spent most of my life trying to get free, at the same time as being extremely grateful for much of it.

I read Latin and Greek (with English, French and history) 'til I was 20 and I went to Oxford as a classical scholar. So languages only. Until the age of 20 I did not experience a single hour of science. At that age I committed myself to medicine. A major point is that that was in October 1939. I regard that point in my life as the most muddled one and one that I'm perhaps rather ashamed of. I went into medicine for reasons which, together, may make some sense, but they were certainly unusual.

MULLAN: With so little background in science, what brought medicine to the fore?

HORDER: Several reasons worked together, but the decision was sudden.

I had got disillusioned with where my classical education was leading me. My family thought it was the only sort of education and my sister had done brilliantly in that direction. But I did'nt see where it was taking me.

In the meantime, I found myself in a college at Oxford which was full of economists. The head of it was William Beveridge. G.D.H.Cole was in the room next to mine and Harold Wilson, later

seemed to be an economist. I thought they were all going up the wrong street, because I believed that what mattered was human nature. I did not perceive that economics is very much about human nature, something I have realized much more recently

I was getting very interested in both philosophy and psychology. Eventually, if I had gone on, I would have been reading philosophy, because that's what Latin and Greek courses traditionally led on to, for centuries.

I was also at this time wanting to be a musician, because my family background was artistic. My mother was a musician and my younger sister an artist. (I did have an aunt who was a devoted nursing sister at St Bartholomew's Hospital, London, and there was a famous cousin of my father's who was the King's doctor, but those two people had no influence on my career choice). My teacher, in Paris, whom I greatly respected, told me that I was not good enough to succeed as a musician. That troubled me at the time, but I am now deeply grateful , because he promised to get me to a point from which I would never give up playing music as an amateur. That has proved true. I have a piano lesson this week.

The most important element in my sudden switch of career choice was the war. At my school the majority of masters had been pacifists who did not keep quiet at the time when Hitler was getting going. Hitler himself was very much influenced by a vote in the Oxford Union in which a majority of the students had voted that they would not fight for King and country. I had great

difficulty about the idea of killing people. I think, quite truthfully, I was more concerned about that than about being killed myself.

I went to my classics teacher to discuss all these problems and I said that, if I survived the war and came back, I wanted to study human nature. That was the sort of abstract statement that one could make at that age. My tutor, as it happened, had a secret desire to be a doctor. He suggested that I should talk with the medical tutor, a particular friend of his. I went to the medical tutor and told him what I hoped if I came back from the war (I had still two terms left at university before I reached the age to be called up). He said: 'If you want to study human nature, you will need to study its pathology. Why don't you become a doctor?'

I said: 'Right. I will'. I took a snap decision. For six or seven years afterwards I wondered whether I had made a mistake, especially when I came back and started. Perhaps this was partly because of my total lack of scientific background; perhaps it was partly because of the way medicine was taught during the war. I found it a difficult experience, inferior to what I had been doing before. Teaching in the medical school at that time seemed very factual, practical and certainly not interested in anything from the neck upwards.

MULLAN: This was at Oxford?

HORDER: Yes

MULLAN: So you transitioned immediately?

HORDER: I transitioned at the start of the war, but I knew that I would have to go into the army two terms later.

MULLAN: Two terms later?

HORDER: 1940.

MULLAN: So you began the study of sciences at that point?

HORDER: I completed all my sciences in those two terms, which is ridiculous.

MULLAN: Did you find it difficult, and did you find it simpatico or alien?

HORDER: Alien. The whole of my previous education had been about people and books and literature and ideas. I had had wonderful teachers.

My hope for the immediate future was now to become a stretcher bearer in the Army Medical Corps, but I was actually not allowed to. I became an ordinary private soldier and later

an officer. I became a battalion signals officer in an elite regiment which later went to Egypt and then to France in 1944.

Fortunately for me, in 1942, a family history of depressive illness caught up with me. When I recovered, I was given the choice of becoming a training officer for signals (at which I was no good) or going back to continue my training as a doctor. So, in the middle of the war, I opted to continue my training at Oxford and later at the London Hospital

My wife, meanwhile, was now ahead of me as a medical student. Her decision to do medicine had been completely independent of mine.

MULLAN: When had you gotten married?

HORDER: In 1940, just after the defeat of France.

MULLAN: You had met where?

HORDER: We had met in Paris two years before, at the ages of 18 and 17.

MULLAN: You were both studying at this time?

HORDER: We both studied French there. I was also studying music. Later I did my medical training, first at Oxford, then at the

London Hospital where I was a clinical student. After qualifying, I did two and a half years in junior appointments at the London Hospital and I began to enjoy medicine only at that point.

MULLAN: This was after you had gotten involved in the clinical aspect of medicine.

HORDER: Yes and after I had qualified. But I had been married by that time for eight years - and my boss would only allow me to go home once a fortnight, That was hard.

MULLAN: This was at the London Hospital?

HORDER: Yes. It was bad for my family, because we had two children by then. I was one of the first people to come back from the war. But the really important thing I want to say is that I was only just then beginning to feel sure that I was enjoying medicine.

The whole of the way through my student period and as a house-officer (our name for an intern), my intention was to do psychiatry, because of my original intention, in changing to medicine, to study human nature. So I did most of my house-appointments in subjects like neurology, neurosurgery and general medicine - and I also worked part-time in the psychiatric department. The head of that department, who was a distant

cousin, put me in the most difficult outpatient clinic, with very hopeless people, to test my vocation. At about the same time I undertook a psychoanalysis, because I thought this a good idea for training.

I think I knew that I had a problem myself about depressive illness. My father, my mother, my grandfather and several other close family members had experience of this trouble. So I thought that an analysis might be therapy as well as training. In fact, the analysis had very little effect on me. I was analytically minded at that time, probably because of the religious and educational background. It was this that made me choose a Jungian rather than a Freudian form, although , later, I had a bit of Freudian analysis.

Just to pursue that important element in my life, I experienced severe depressive illness three times. I was eventually persuaded to take medication continuously. I've only had one short episode in thirty years since then, with an obvious precipitating cause. It seems now rather like being a diabetic on continuous treatment and I cannot doubt the benefit (it is recorded on a chart, kept over forty years).

MULLAN: With the new generation of medicines you did'nt switch?

HORDER: No. I have to add that I can eat cheese and all the other things one is not supposed to eat with mono-oxidase inhibitors,

as indeed could my mother, when the same thing happened to her.

Going back now, a crucial point in my life was in 1952, when I was looking for a new hospital job, still intending to be a psychiatrist. To fill in, I did a locum job in general practice. I suddenly realized that this was what I was looking for and had been looking for all the time.

MULLAN: This being general practice.

HORDER: Yes. It was a bit like a religious conversion. It had a very marked effect and I threw the whole weight of my enthusiasm into it. You see, it related to my earlier training, which was about people and not at all about the analysis of bodily functions. This was a time when practically none of my contemporaries would have admitted to wanting to become general practitioners, and my teachers thought I was mad. I went to work in a shop in a poor part of London.

MULLAN: In a shop, being a practice?

HORDER: Yes a shop - a very old-fashioned one, had'nt changed since 1880 when the practice started. We've probably got some pictures of it here. Nevertheless, I was very enthusiastic about it. Yet this was a time when people were saying that general practice could'nt survive, for reasons which must be familiar to

you in America. So there was a tremendous challenge. I felt that the job was really important and I was sure it was the right one for me. My wife, too, was doing it - although this is not necessarily an easy arrangement

It so happened that the College was being planned in that same year and I joined it immediately.

MULLAN: This being the Royal College of General Practitioners?

HORDER: Yes. This again has been an extremely important element in my medical life. I had found myself, at first, among a group of doctors who were unhappy because of the changes in the Health Service (it is always the unhappy people who are the most noisy). I had worked until then in a teaching hospital as a 'registrar', but now I found, if I wanted to get a patient into the local hospital, that I was challenged by younger doctors who seemed to think that I did'nt know anything. One was very much diminished. I resented that and I wanted to do something about it. The College has made that possible, has actually achieved change over the years.

I began work at the center of this national College very soon, largely because of living and working in London. I started the archives and the library about 1953. Then Dr John Hunt, who was the essential figure in the College's atart (and then

Honorary Secretary of its Council), asked me to be the Assistant Secretary. That was going too fast and it had a lot to do with my first breakdown. I had to give up that post. That brings us to 1956.

MULLAN: Tell me a bit about entering into general practice. When you encountered the possibility, it suddenly made sense to you that this was what you wanted to do. As you undertook practice, was it indeed gratifying? Did it speak to your interests?

HORDER: It did. I thoroughly enjoyed working in people's homes, I thoroughly enjoyed the relationship - and that has been a persistent feeling. Something I wrote last year was about this being at the center of the job. You can call it biographical medicine, I suppose. That includes long-term continuity, to which I attach more importance perhaps than others do. It gave me a chance to pursue my interest in human nature, in psychology and psychiatry, without giving up everything else in medicine (by this time I had got interested and had passed the membership examination of the Royal College of Physicians - a hard one, intended for general hospital physicians). So it simply was the right spot in medicine for me and I have never changed my mind about that.

MULLAN: Were you practicing with your wife at that point?

HORDER: Yes, because we were in the same partnership, along with one older doctor, John Wigg, whose father had started the practice about 1885. But we had two different places of work. One was just up this road, the other a mile away to the east, in a much poorer area. On the whole she worked mostly there, I mostly here. We did'nt find it easy. Our attitudes to various aspects of medicine, particularly et first, were different to each other. So it could be quite a stress. Although I enjoyed my work, I took it hard too often and used to get very worried about people. My wife had to protect our children from that. She managed to work two-thirds of a day, never a whole day. We had help from twenty-eight foreign au-pair girls in succession.

MULLAN: Twenty-eight?

HORDER: Yes, twenty-eight, together with a part-time daily helper who stayed with us for about the same number of years.

MULLAN: And you had how many children?

HORDER: Four. Looking back, I just don't know how my wife did it all. She was tough.

MULLAN: I think we were talking about your career in the fifties. We'd gotten you into practice in the early days of the College.

Why don't we pursue that, following one theme or the other? I think you were talking, when I distracted you, about your early work in the College and how that developed. Maybe you can pick up with that and proceed.

HORDER: The College, I think, from the start, meant the possibility of linking together what was a very large, fragmented series of practical problems. General practitioners of my generation and before were essentially practical people whose thinking was done by other people and who tended to despise reflection and theory.

This problem has gone on as we've been establishing departments of general practice in medical schools and universities. They have had difficulties with their own people. Indeed they have difficulties on both sides (I'm moving nearer to the present time). They have been regarded as odd and rubbished as 'academics' by their colleagues in practice who were not interested in teaching or research. But they have also sometimes been rubbished by specialist colleagues for being inadequate as specialists. Perhaps the second is the more fundamental and difficult problem and it is certainly central to what we are likely to be talking about.

But, to go back, I was saying that the College began to make a means of making links, between both people and the problems they had to deal with. For me it also offered the possibility of

getting back into the sort of world that I'd known before. I've already described my family as dominated by my nonconformist clerical grandfather. But there was also a rather strong academic tradition through my elder sister and brother-in-law, and indeed through both my brothers-in-law, who are both physicists. One is a Nobel prizewinner and the other recently became President of the Academy of Sciences in France.

So, by becoming a general practitioner, I was taking myself out of a socially and academically superior world into what felt to be an inferior one. But I was sure it was the right thing to do. I even think that it may have been in itself a contribution to the problems of general practice at that time, because I belonged to a family which had produced one of the best-known doctors of his day (although called a specialist and based in hospital practice, he acted sometimes as a general consultant and numbered two of our Kings among his patients)). So I carried the same name into what was then regarded as an inferior branch of medicine.

I feel that this was a symbolically important thing to do, just as going to work in a shop in a poor district was symbolically important. But I do not want to put only high motives to what I did at that time, because there were other expedient reasons for doing it. I was already married, with four children. My wife was already involved in this role. I was somewhat disillusioned with my proposed career in psychiatry. Nevertheless, when I say that I had a sort of conversion, feeling

that general practice was not only right for me, but also an important role in society, I'm being totally honest. That conviction has carried me through thirty or forty years. But it would have been far more difficult without the College, which has allowed me to link again to the sort of university background which had become familiar to me.

The other side of the coin in the 1950's was that it was an oppressive time. Recruitment to general practice was now falling. It had been rather favorable just after the war, with people coming back. It was that generation which created the College. They had been through the war, they were rather older. Most of those who became best known later were of that generation, twenty-eight, thirty, up to thirty-five.

Locally I found myself in a branch of the British Medical Association with very disillusioned people who were angry about the new health service because they thought they were underpaid and overworked. A great deal of the talk was about money, which was sad in itself. They were angry because they had lost the right to sell the practice which they had bought. Some of them had lost the right to work in hospital, where they'd enjoyed working, because, unfortunately, they were still very hospital- and specialist-minded. This, of course, made them despise what was now their proper work. They'd had to go into general practice when they did not really want to. These were the sort of people one found around at first.

But then the College had its first local meetings. I'll

never forget the first one I went to, where I discovered an entirely different sort of general practitioner. They were highly selected people whom I found very much to my heart. I'm thinking particularly of two or three of them. They had good brains and were very idealistic. This was an enormous support.

MULLAN: What had led to the formation of the College?

HORDER: It's quite a long history actually. It was attempted in the middle of the nineteenth century, but it failed in Parliament. The whole idea died then, until the nineteen-forties, when a number of people proposed something of the sort. But the crucial character was John Hunt, who had been destined to become a consultant at a major teaching hospital, but who, suddenly in 1937, decided to be a general practitioner. There was a degree of mystery about what made him come to that decision, which I did'nt entirely resolve when I was writing about his life.

He was a powerful character and a tremendous worker. Such other motivations came into his life as that he lost his eldest son, in 1947, as a child, and needed to compensate for that. However, I must'nt say that it was all due to one man. Without him it would have been much more difficult and slower. It would probably have come anyway.

What was then becoming so clear was that the profession was divided into an upper and a lower part. Those in the upper part

had extensive postgraduate preparation for the work they were going to do; the lower part was not prepared adequately at all. People could go straight into general practice when they'd left the teaching hospital, where they had been taught entirely by specialists. When I was a student, I saw one general practitioner once, who happened to be visiting one of his patients in the ward where I was working. I was really programmed to despise general practitioners by some of my teachers, who would always be selectively critical about the bad letters of referral they received - never about the good ones.. One can meet such in every country, of course.

So there was a good reason for why the College started then, but it required particular people. This generation coming out of the war seemed to be the right ones at the time. It was generally a time of hopes, optimism and big initiatives. The National Health Service was itself part of this movement. We had a Labor government which had thrown Churchill out, in itself surprising. The desire to rebuild was powerful and a great many things were done.

MULLAN: The College, as it was formed and as it exists today, is largely an instrument of professional focus, as opposed to a standard-setting or credential-granting institution. Is that correct?

HORDER: I think it's both. It certainly is the second. It provides the only test of competence for this branch of medicine.

MULLAN: So it does do testing?

HORDER: Oh, yes. It has an examination which is taken by almost everybody now. It is very difficult to get a job as a GP without passing this examination.

So the ideas about the College at that time were really the ideas that have motivated it ever since, although with some changes - it was essential to create a special training after qualification (I think that's still the most important achievement of the College); it was essential to introduce the discipline of research into this field, where it virtually did not exist. Previously there had been only two famous people who had managed to achieve important research - James Mackenzie and Wilfred Pickles (unless one goes back as far as Jenner).

Perhaps less fundamental was the challenge to develop practice organization and tools for the job.

There was also a need to represent this branch of medicine (which was , even then, half the profession) towards government. But this made a problem. On certain issues the other Royal Colleges had long since represented their part of medicine towards government, alongside the British Medical Association. In the previous absence of a College, the British Medical

Association had often represented general practitioners for purposes which were not to do with remuneration or terms of service. The Association inevitably saw the College as an interloper on its own territory, although their functions are really sufficiently different that, given careful management by the people at the top, they can work together and not in conflict. From time to time there has been tension between the two.

I must stay with the nineteen-fifties. My own first role, as I've told you, was in starting the College library (and archives). This continues to be an important department. But then I began to get increasingly concerned about the lack of any special training. In 1948 the British Medical Association had put forward the essential ideas for special training, of which there was then none. This was under someone called Henry Cohen, Professor of Medicine in Liverpool and a very intelligent, far-sighted man. He was not a general practitioner. The British Medical Association simply dropped that report and did nothing about it. The College picked up the theme in 1963. I was very much involved by then and I wrote, as committee secretary, the first reports which proposed this. They were submitted to the Royal Commission on Medical Education in 1966. Its report (1968) was very strongly influenced by college ideas

MULLAN: This is towards establishing specific postgraduate

training for GPs?

HORDER: Yes. We originally proposed five years. It got reduced to three years , for reasons of expediency. Previously the College had gone ahead in promoting research, My first job had also been as Assistant Secretary of the Research Committee. But I moved into education and away from research because of my lack of scientific training. I stayed on the education side for most of the rest of my time in the College.

During the whole of this time I had another basic motive. This was to influence the balance between the physical and the psychosocial aspects of this part of medicine. Doubtless this related to my earlier career intention and to my earlier education. I was very troubled by the solely physical interpretations of patients' problems that were around at that time and had been the same in my medical education.

MULLAN: As opposed to psychological?

HORDER: Yes. Many of the papers I wrote at that time were about the psychological and social aspects of general practice. Indeed I was on the first college working group dealing with that subject, in 1956.

Then I went to the World Health Organization (WHO) as a consultant in Geneva in 1960. I think I was probably the first

general practitioner to be taken on there as a consultant to an Expert Committee. This was about the role of general practitioners and public health officers in psychological medicine. Professor Lemkau, from Johns Hopkins, did the public health side.

That was a tremendous experience for me, because I came out of a small shop in London and suddenly found myself looking at the whole world (and simultaneously looking out of my window at a marvelous view of Mont Blanc). It was an exciting year's work, not all of it done in Geneva - only about four weeks had to be spent there. A real revelation for me.

MULLAN: This was a sabbatical from your practice?

HORDER: Yes.

MULLAN: Someone else covered?

HORDER: My partners were wonderful about my various absences. They were unbelievably generous

MULLAN: Tell me about how the practice developed over those years in the fifties and sixties.

HORDER: Well, first - our senior partner, John Wigg. I want to

go back a little on his history. It was his father who started the practice.

MULLAN: W-E-E-G ?

HORDER: Wigg. His father had come from the London Hospital, where he had been trained, about 1885, and gone straight into this practice in a poor neighborhood in London, much poorer then, in the same shop as I started. He was himself relatively poor, for years, because you could'nt make a good living in that area. If you were perhaps in Hampstead, where rich people lived, you could make a good living. Doctors in Hampstead would'nt talk to doctors in Kentish Town in those days. Kentish Town was the sort of neighborhood where people had to pay what they could. If they needed three stitches to sew up a wound, they would only get all three if they had three sixpences. Otherwise they got one stitch.

John Wigg, our senior partner, was very much concerned and influenced by the poverty of this neighborhood and by his own economical upbringing. His family's situation had improved in 1911, when Lloyd George brought in an Act of Parliament which gave sickness insurance to wage-earners. It did not cover their families. But it brought more security to general practitioners.

So, at this point, Dr James Wigg (senior) moved from above the shop to the road where we are now, but further along. He set up not only his home there, but also what we call a 'branch

surgery'. So the practice was already based in two places when my wife and I joined it (she first), but only a mile apart. It was a continuous practice area, by that time dealing with a very mixed population, some of it very rich or very intelligent, some very poor or of low educational level. John Wigg was also interested in psychological aspects of medicine and, in fact, had spent much of the war years doing psychological testing to select officers for the army.

There were three of us when I started; that's to say, him, my wife and me. My wife had started in 1947, so she just experienced the regime which preceded the National Health Service of 1948. Both John Wigg and she had very much resented having to charge patients and they were relieved when the Health Service came in and they did'nt have to put their hand out for money. We had one receptionist, who was tremendous - a local girl.

I had only been in the practice for a year or two when we decided to change this shop into something up-to-date. It was literally as it had been in 1880. There was an old-fashioned desk, there was a couch, there was a sterilizer, there was an old grandfather clock - and the books in the bookcase still dated from 1880. Over one weekend - two days -the place was transformed. I've never seen anything quite like it. We suddenly had a completely new set-up. That was about 1953.

From that point on we just increased. That's easy in the middle of a big city. If you're any good at the job, people come

and sign on the list. So we had to take on more doctors

MULLAN: How large did you grow?

HORDER: We grew to six, rather rapidly. At this point we thought we ought to stop. It was getting too big. The next development after that - around 1960 - was to make a link with nurses and health visitors, because they had been separately organized up to that time. Communication with them was not only weak, it was actually often missing. They were people we never met.

This is in fact at the root of the work which I have been doing for the last ten years; it stems from that early experience of bad relationships with other professions.

To turn back to the College and the question of developing a special training -I remember, when we had made our plans, a very moving occasion. We had just got the training plans publicized. We were terribly worried because here we were proposing at least three years more training, when young doctors had already done six years and when recruitment to general practice was already difficult. Would we put them off entirely? What actually happened was that they flocked in. It was extremely interesting. They actually lost money for a time by taking the new training rather than going straight into practice. It was all voluntary.

MULLAN: They wanted to do it?

HORDER: They wanted to because it upgraded the job. It made them feel that the job was more worth doing, because training was now needed for it - and anyway they wanted to be as well trained as possible

MULLAN: when was it that it began?

HORDER: the first local experiments started, as did the central College group, about 1964 - at least, so we thought, until we discovered that a local scheme had been hidden in Inverness (N.Scotland) ever since 1952.. Otherwise the earliest three schemes were at Manchester, Ipswich, Winchester and Canterbury. They happened in those places, of course, because there were keen individuals there responsible for starting them.

So the policy was to let these training schemes develop in their different sorts of ways in different places. But pretty quickly they all took the form of two years in hospital posts and one year in a training practice, with a day -release course weekly throughout. That became the standard path, as it has largely remained until now.

In 1968 there was a Royal Commission. A Royal Commission was then an absolutely top-level government committee which usually went on for a year or two.

MULLAN: You are talking of the Royal Commission on Medical Education?

HORDER: Yes. The Royal Commission was dealing with the whole of medical education, both before and after qualification. It still faced - despite the experiments I have talked about in the postgraduate training of general practitioners - a general situation in which the specialist half of the profession had extensive special preparation for their work, after they qualified, sometimes continuing until the age of forty. The general practice half still had no obligation to undergo a special training, although, in reality, by this time, most future GPs were doing something to help themselves in this way. There was already (since 1948) something called 'the Trainee Practitioner Scheme' which paid for one year's experience in a practice, under supervision, but this was voluntary and not undertaken by many. Incidentally it had originally been introduced for reasons other than training.

What I am trying to say is that the Royal Commission, twenty years after the National Health Service started, faced this very marked difference between the two halves of the profession. It was actually in their hands, in their power to decide whether general practice in this country would have a future or not. I think that they debated this long and hard. They decided that the existing state of general practice was sufficiently strong that

they would back it. If you look at this important report, you can see that it was actually dominated by this decision. The report starts with the problem of general practice. So you get this major change, by which every branch of the profession - for the first time in this country - gets a special training, thereby releasing the undergraduate curriculum to become more of a university type education - at least in theory, because it has proved difficult to develop that

MULLAN: Which year was it that this actually went into effect?

HORDER: It was recommended in 1968 and it gradually came in the next few years. I find it a little difficult to say precisely, but by 1980 it was obligatory. You could'nt become a principal in the National Health Service after that without having taken this training. It was made obligatory by Parliament out of fear that some general practitioners might escape it if it was voluntary. Their motivation might not be strong enough. That may have been a mistake. Anyway the government was putting money into it already during the 1970's.

MULLAN: And people were responding positively?

HORDER: Very positively

MULLAN: They were continuing to select general practice?

HORDER: They were beginning. This was the turning point in recruitment. But there was another important thing which must also be mentioned. This was on the British Medical Association's side; it was'nt very much the College. It was a bit of both, but mostly BMA.

Relations with the Government were quite stormy in the nineteen sixties and at one point it came to the threat of a strike by doctors. But then we changed to a Labor government and had Kenneth Robinson as Minister. He was the son of a general practitioner. He made a good relationship with the BMA and the College and introduced a lot of changes in the regulations - they were called 'the Charter' and were really a combined operation between the profession and the Government. From this point on general practitioners were paid to take on nurses and secretaries (called 'ancillaries', to their annoyance). 70% of their salaries was paid by the Government, for the first time. So the beginnings of teamwork became possible.

There were a number of other changes. For instance, there was a payment (ongoing) for having completed three years of vocational training after qualification, as well as payments for trainee and trainer during the year in a training practice. So there were considerable financial gains for most doctors.

MULLAN: Were these proposed by the College?

HORDER: They were originally suggested by the College, but the credit for the negotiations must go to the BMA - the political arm of the profession, and to that Government. (Interestingly, I shall be seeing Kenneth Robinson next week. He is over eighty now.

(p.s.1996. He died this year)

MULLAN: So during the period of the sixties and seventies, I gather the development of the idea and the implementation of the concept of vocational training for general practice was both an accomplishment of the College and the accomplishment of yourself in terms of your stewardship of that committee and that activity.

HORDER: It was certainly an accomplishment of the College. I just happened to be secretary or chairman of that committee at the time and I was very keen on it.

I continued to be concerned with it for at least the next ten years, partly in other European countries.

If we are talking about myself, I've already mentioned my concern to try to influence the balance between physical and psychosocial aspects of diagnosis and treatment. I haven't up to now mentioned that I was a member of an ongoing seminar run by

Dr Michael Balint, a psychoanalyst. He was important because he believed in general practitioners at a time when most people did'nt. Do you know about him?

MULLAN: I do, and Marshall Marinker told me about the groups that were very exciting that he ran.

HORDER: I was in the first group (1954). I found it quite difficult, because it was really a matter of looking at the doctor; so we were exposed in the group. But it became very influential. I think it probably had more effect on me than my own analysis. (Forty years later I'm still indirectly involved - not with him,; he is dead; not with his wife and partner, Enid, but with her subsequent husband, whom I shall be seeing tomorrow).

The Balint group has become a worldwide movement in a small way. It has been a major influence, I think, in general practice and family medicine because of its emphasis on understanding the relationship between doctors and patients, which is its central theme, and its profound analysis of what is going on in the consultation. It is a contrasting influence, for instance, to the epidemiological activities which also made a big impact on general practice

In 1972 - I expect Marshall Marinker mentioned this - six of us got together at the request of the College, four of whom

were Balint-influenced people. We wrote what was eventually called 'The Future General Practitioner - Learning and Teaching'. In the first place this book was actually rejected by the College Council, because it was regarded as biased. It was trying to do exactly what I have said. Curiously, within a year, it had become a sort of standard textbook for the College examination. I don't really know how that switch happened.

From that time on, Balint's ideas, which had been unattractive to most general practitioners, became, as it were, College policy, and psychiatry became respectable within general practice. Before that it had been despised as something peculiar, something not quite as it should be.

MULLAN: At what point did the College start giving examinations? Was that about in the fifties?

HORDER: I would say in the early seventies. We can check that.

MULLAN: The examination was voluntary?

HORDER: Yes.

MULLAN: Followed the vocational postgraduate training?

HORDER: Yes.

MULLAN: And it was, I presume, a written test, as opposed to an oral exam?

HORDER: It was both written and oral, but there were no patients. It was too difficult to organize that. There was a constant concern to introduce them, but it has never been done. Instead there are simulated patients. Examiners themselves partly act as patients. The exam has been a tremendously worked -on activity. The body of examiners meet very frequently. They're extremely keen. They sometimes become a sort of loose cog in the College machine because they form such a tight group. There was a point in the eighties when there was quite a battle between them and the Council. They are constantly trying to improve the exam.

MULLAN: That now is a quality assurance standard or hurdle for people entering general practice?

HORDER: Yes.

MULLAN: And pretty much everybody since that time has taken it?

HORDER: I think the figure is somewhere about 80 or 90%, but I would have to look that up.

MULLAN: But you can't enter practice without having taken it?

HORDER: You can't enter practice in the National Health Service without having taken it. No. I'm wrong. You can't enter practice in the Health Service without having completed the training. The British Medical Association has always opposed the College exam being a requirement for entry. That's still an issue today. It's a matter of rivalry between the two organizations.

In the nineteen seventies I began to get very interested in other countries in Europe. There was a conference in the Netherlands, I think, in 1972 or 1973, at a place called Leeuwenhorst, which is in the middle of the Dutch bulb fields. We were discussing training. With a young Dutch doctor, sitting next to me, Niels Bentzen, who is now a professor, I proposed that we should have an ongoing group on the European level. We got eleven countries represented - and produced rather quickly an agreed definition of a general practitioner's role in Europe. This has held until now as a standard definition of what a the general practitioner's role should be. So during the next ten years I was often going to other countries in Europe. To a lesser extent, I still do.

MULLAN: You remained in practice through this time?

HORDER: Yes.

MULLAN: Was the practice vigorous and satisfying?

HORDER: The practice was very vigorous. My aim in it was to create a center of thinking as well as of doing. It was about 1970 that we began to plan to move into a specially-built health center. I haven't said, up to now, that our practice had already been receiving students from University College Hospital since 1954. The new health center was built with the help of the Professor of Medicine there, Max Rosenheim, later President of the Royal College of Physicians. It had extra accommodation for teaching purposes. Basically it was built to house two group practices, our own and a neighboring one. We had beliefs in common, except that they were more left-wing, indeed several of them had been members of the communist party, until disillusioned. But we worked easily with them.

It took six years to plan this center and about a year to build it. It was built by the local authority, Camden, so it was not our property. The relationship with the Community Physician (Medical Officer of Health), Dr Wilfred Harding, was so good that we never even had a written agreement. There was one point when we suddenly found that our rent had been halved without our asking for that. Dr Harding regarded this health center as his most important contribution to medical care, so we were able to pick the best possible nurses, health visitors and all sorts of other staff. The center is still flourishing. There must be about a hundred or more people working in it.

MULLAN: All within one practice?

HORDER: No. Two practices, two groups sharing the central area where the nurses worked with both groups.

MULLAN: And you were there through 1980?

HORDER: I was there until I retired in 1981, when I had a coronary occlusion, at a time when I was also President of the College.

This center is in an area that, as I may have said already, had been very definitely poor. It had become a mixed area since the second world war, mixed in social class, mixed in race. It was already a partly Greek Cypriot area by 1970. All the churches in the neighborhood had become Greek Orthodox. But there was beginning to be another sort of population there, particularly academics, civil servants and Labor politicians. It was not too expensive for them to buy houses there. The main interest of the practice was in the extraordinary diversity of people who sat down next to each other in the waiting room - quite happily.

We were all motivated by a desire to make the health service work. John Wigg had chosen us for this concern and we did the same. I think we made it work as well as we could. The teaching activity, which included both a continuous flow of students - always four in the center - and at least two postgraduate doctors

in training, created a tremendous intellectual stimulus. We had meetings over lunch three times a week, in which we mostly discussed cases, sometimes in the presence of a visiting specialist (for instance, in psychiatry). These meetings became the basis for my present concern with interprofessional relationships. Because the same people were regularly together, it became possible for them to start talking about their mistakes and their ignorance. They felt safe enough to do that. I now see that as a crucial element in interprofessional cooperation. If people stand on their dignity, they don't get along with each other.

MULLAN: You served as President of the College for a period?

HORDER: Yes, for three years. By that time I had also got very involved in promoting preventive medicine. I was pushed into that.

MULLAN: This was the late seventies?

HORDER: Yes. I was influenced by two people. One was a general practitioner, Christopher Donovan, with whom I have worked since he came to me as a student. The other was Professor Jerry Morris, Professor of Community Medicine .

MULLAN: Professor at?

HORDER: The London School of Hygiene, London University. He p pointed out to me that, with 1500 young postgraduates being trained for general practice in this country each year, we had an enormous opportunity to influence the future. On that basis I started a series of working groups in the College which later published several reports on different aspects of preventive practice.

By the time I was President, I think I had done most of the things that I would recognize as the most important ones. I think this goes for most of my fellow Presidents. When they are in post, the job is different - more representational and diplomatic. Presidents can add their weight to things, but they do not have much time to withdraw and do the basic thinking and produce new ideas of their own. But I found it a tremendously stimulating experience - and also very exacting. I was very lucky to work throughout with a Chairman of Council, Alastair Donald. There are two senior officers in this College. The two of us fitted together beautifully. I produced ideas, some of which were quite impractical, but I knew that he would sift them and that nothing would go through which was unlikely to work. He himself was President ten years later.

I suppose it was the most stimulating three years of my life. I worked extremely hard and in the middle of it I had a coronary. That was when I left the practice.

MULLAN: And you spent the last decade, as you described to me, with a couple of enterprises. Say a word about that.

HORDER: I was at the Royal Free Hospital School of Medicine for most of that time, allowed to choose what I did. At first I became a medical student, going round with a small group of students, both sharing and observing their work. Unfortunately that only lasted eight months.

MULLAN: At the Royal Free Hospital?

HORDER: Yes. This is one of what used to be twelve medical schools in London, but now reduced to five through amalgamations. It is in a fairly new building with hospital and school side-by-side in Hampstead. It was one of the smaller schools, with an annual intake of 100 - a good thing. But is has now been joined with University College and the Middlesex Hospital schools to make one big school. In trying to be a medical student again, I copied an American Dean. But he did the job properly and kept it up for three years, then wrote about it.

MULLAN: Where was that?

HORDER: In the New England Journal. In my case, I reported to the teachers, in particular to the Professor of Medicine, on what the

students were feeling about the course, so it was quite useful. The most important thing I found was their great need for personal tuition when they go into the wards for the first time. They don't know what they are doing or whether they are doing it right. They don't know the meaning of whatever they find. They feel very anxious and need personal support.

It was at that time that I began to get seriously interested in promoting interprofessional education. This had little to do with the Royal Free Hospital or School. I was allowed to function outside. I began then to create a national organization to support people who were actually doing this work. It was already happening in a number of centers. That was ten years ago. I was carrying this almost alone from this house for a time, but about five years ago we managed to get a room in the London School of Economics, chosen because of its interprofessional neutrality.

This was a difficult time, for various reasons, and we left there two years ago for an independent office in a building belonging to the Open University, where there are lecture and seminar rooms at our disposal. The main problem in this venture is finding money to pay the small staff. I have recently passed over the chairmanship to Sir Michael Drury, who was also President of the College of General Practitioners, but I am still involved.

In the meantime I have had a lot of things to write. They have been varied. I wrote about the life of John Hunt, the main founder of the College, as a preface to a collection of his

writings. Then there were things to write for a working group of non-governmental organizations at WHO in Geneva. Oddly enough the subject was the same as I had undertaken thirty years earlier - the role of the general practitioner in mental health and illness. Then there was a chapter of a book for trainees on the meanings of 'health' as opposed to illness. This was difficult. Finally I helped John Fry in writing about primary care in ten countries.

MULLAN: That's a good transition to talking more analytically about where we stand now. Having been engaged in the research and writing of that volume on primary care in a number of European countries, what are your views?

HORDER: Not just European - USA, Canada, Japan, Singapore, Hong Kong too.

MULLAN: The better to comment on the world. What are your views on the health and well-being of the global primary care movement. the global generalism movement?

writings. Then there were things to write for a working group of non-governmental organizations at WHO in Geneva. Oddly enough the subject was the same as I had undertaken thirty years earlier - the role of the general practitioner in mental health and illness. Then there was a chapter of a book for trainees on the meanings of 'health' as opposed to illness. This was difficult. Finally I helped John Fry in writing about primary care in ten countries.

MULLAN: That's a good transition to talking more analytically about where we stand now. Having been engaged in the research and writing of that volume on primary care in a number of European countries, what are your views?

HORDER: Not just European - USA, Canada, Japan, Singapore, Hong Kong too.

MULLAN: The better to comment on the world. What are your views on the health and well-being of the global primary care movement. the global generalism movement?
Is it fair even to call it a movement?

HORDER: I see the most persistent problem as being the role of the generalist in the presence of increasing specialisation. But, paradoxically,I believe it is less of a problem now than it was

thirty years ago. The more specialisation develops, the more it fragments. It has an internal logic which makes this happen. Therefore, the need for somebody to hold things together becomes more and more obvious. That's one theme. The other parallel theme, of course, is economic - again showing the nonsense of my original ideas, when I was a student, about the non-importance of economics. It seems to dominate the world now.

Most governments seem to think that primary care is inherently cheaper because of its need for less complex equipment and its potential to control access to expensive specialist care. There is good evidence from your country, in particular, about reduction of costs through the introduction of health maintenance organisations. There is also good evidence from Sweden through the new develpment of primary care.

The main reasons why primary care has been particularly flourishing in this country here are two - first - the original support from the Health Service which required every citizen to register with a general practitioner and - second - even more important - the referral system, consistently maintained by the population and the specialists as well as by the general practitioners. Specialists like it because it allows them to concentrate on their special work and skills and frees them from problems outside their specialty, which they are not always good at dealing with.

But a basic problem for the generalist seems to me to persist - he or she must so often compare themselves with people

who are concentrating on a much smaller area and must be expected to do better within it.. We know from American studies that they do do better, but only so long as they are working in their special area. Once they leave that, they do less well than the generalist. But this remains for me a worry, although I now see clear distinctions between the responsibilities of generalists and specialists overall.

MULLAN: In terms of development here in this country, with stakeholding, with reform in the National Health Service, do you think that the GP is going to come out of this stronger or weaker?

HORDER: I think, given a few more years and further changes of policy, GPs are going to come out stronger. If the development of budget-holding practices goes forward as it now needs to do, it really does give a considerable degree of control to the generalist. This is a new situation.

I have spent most of my professional life trying to promote the role of the general doctor, yet I have always had a feeling that it may not be right to promote a particular professional group - it is not necessarily for the benefit of the population. That is one of the influences which has driven me into interprofessional work in recent years,

One of my concerns is whether the population, as it becomes

more medically sophisticated, will be satisfied not to have freer choice and freer access to specialists. Up to now the referral principle has held firm here and, as I have said, has been a particularly important reason why primary care has flourished in this country., but not in many others until now.

Another concern for the future of doctors in primary care is about the aspirations of nurses. The nurse practitioner idea makes thoroughly good sense on your side of the Atlantic in places where there are not enough doctors. Hitherto there has been no shortage of doctors in this country, but many nurses are discontented with their role and they have grabbed at the nurse practitioner idea. It is very likely that the government will see this as a cheaper option.

MULLAN: Have they begun to train nurses at the advanced level?

HORDER: Yes, and they are keen on it. I fear that nurses will try to sell the idea that they are the right people to do the caring and that doctors should normally be called in only for technical advice when needed. That system might work. I have seen it work in one place in Israel.

But I believe that the most essential function of the general practitioner is in the recognition and assessment of patients' problems. This can be an intense intellectual exercise if you are really going to pick up all that needs to be picked

up and if you are to think across physical, psychological, social and environmental aspects of a case in a pretty rapid span of time. This can be very demanding and it needs good training without shortcuts.. For example, general practitioners have to be familiar with a greater number of special investigations than any single specialist. The idea that this is a job for doctors who are less well endowed intellectually, as is implied by the system in France, is ridiculous.

MULLAN: That is the prevailing misnomer, misconcept. I think currently the counter-attack to that is coming on fairly heavily, that dealing with uncertainty, dealing with what you have to deal with in general practice, in fact, is harder than what specialists have, where you have a digested, pre-digested part of the population that essentially needs your services. It's hard to sell, but I think it is a terribly important idea.

I also agree that the nurse practitioner phenomenon is worrisome, although I think it really requires attention, because nurses are, when trained at the advanced level, well accepted by the population and clearly competent to do a lot of medical work that takes place. Where you go from there, though, becomes much more problematic in terms of how aggressive we are.

HORDER: It's the sort of problem that works itself out best on the ground - in practice. When you get to working in the same

building over a sufficient length of time, meeting eachother and knowing eachother as people with faces and names, that's very different to trying to work it out between professional groups at a high level.

MULLAN: Let me ask you this. The hour is late. I know I'm fading. There are many areas we could explore and on our next visit we will. Are there any other thoughts you have on general practice or medical generalism, particularly in regard to where it is headed, that you'd like to add?

HORDER: Yes. One comes to me straight away. Because of the natural course of medicine and even because of the education and research of general practitioners themselves, the responsibilities of general practice have become such in this country that work has to be shared around and much of it is delegated. It's not impossible to be a single-handed doctor now, but it becomes increasingly diffiult. Teamwork is the order of the day. But this dilutes the relationship between the patient and any one caring agent. I cannot doubt that the future must be in teamwork, but something important to patients is already being lost.