It has to be accepted, therefore, that within the profession there can be conflicting views and actions that are equally valid in ethical terms; and, therefore, that ethical considerations alone will not provide the answers to all of the problems that the profession has to face in its relations with the State as a near-monopoly employer of doctors.

This makes it doubly important for both sides to avoid causes of conflict to a point at which some withdrawal of services becomes the only remedy for doctors to preserve their professional standards and protect the long-term interests of their patients. Government has a special responsibility not to create such conflict by pursuing purely political ends. The profession has a special responsibility not to create such conflict purely to further the advantage of its own members.

If both sides were to accept these principles the relationship between the profession and the State (and perhaps between other professions and the State) would become clearer and more manageable.

Conclusions

(1) In a national health service, while the ethical responsibility of a doctor to his individual patient remains unchanged, the ethical responsibility of the medical profession itself to the community becomes part of a joint responsibility shared by Government and the profession. If there were some joint announcement of the acceptance of this principle by Government and the profession it would be to the advantage of all.

(2) Both parties should admit that the machinery of consultation now available does not effectively minimise the possibility of confrontation between Government and profession, nor effectively and speedily resolve confrontation when it occurs.

(3) It follows that both parties should admit that the responsibility to the community is not being discharged and cannot be discharged unless some more effective machinery of conciliation is introduced.

(4) It is a matter of urgency that discussions between the Government and the medical profession shall start in order to decide how best such machinery can be introduced.

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Today's Treatment

Diseases of the alimentary system

View from general practice

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In general practice alimentary diseases form the smallest proportion of diseases of the major systems that can be classified in traditional hospital terms, but the largest proportion (nearly one-third) of those handled on a symptomatic basis. The recent national study of morbidity seen in general practice[1] recorded only some 4% of all episodes of illness as caused by classifiable disorders of the system, with a further 4% of episodes grouped under the category of unclassified symptoms relating to the digestive tract. When the wide variations among doctors in their preferences for disease as against symptom labelling is also considered, it can be seen that the difficulty in deciding whether to discuss diseases or symptoms becomes a major one.

Before considering treatment it is reasonable to look at the figures already quoted in terms which reflect the day-to-day work of family doctors. One patient in 12 will present a disorder of the alimentary system, and this will represent three or four consultations during the average day. Nearly half will be acute diarrhoea or vomiting. Dyspeptic illness is next commonest, patients in this category being seen at the rate of perhaps two a week. Depending on policies of investigation, half will have proved ulcers, half suspected ulcers. Most of these patients will not be consulting for the first time with such symptoms. During the course of a year an average of some 20 patients will present with each of the diagnoses aphthous ulcer, dental abscess or caries, hernia, fissure, haemorrhoids, and constipation, although many more will have laxatives prescribed without regular consultation. Except in epidemics, jaundice is a rare condition. From the total of undifferentiated illnesses that include abdominal pain as a symptom (most alimentary complaints are in this category) possible appendicitis is probably diagnosed less often than once a month (and confirmed as correct in terms of needing surgery in half these cases); acute gall bladder disease is about equally prevalent. New diagnoses such as perforated ulcer, haematemesis, ulcerative colitis, obstruction, carcinoma of stomach, carcinoma of colon, and carcinoma of rectum are made no more than once or twice each during an average year.

The general practitioner thus carries into his thinking about treatment of alimentary disease three groups of disorders; the first is of common disorders, difficult to define in precise aetiological or diagnostic terms but usually benign and often self-limiting; the second contains comparatively uncommon conditions which are often materially inconveniencing, fairly easily defined, and usually treatable; and the third is composed of rare but serious conditions that need early recognition for saving life.

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Treatment

It is all too easy to equate "treatment" in general practice with prescribing drugs. While many useful therapeutic agents are available, drugs have a comparatively limited contribution to make to managing patients with alimentary illness. Some general approaches to management may be considered briefly before discussing the treatment of some of the commoner presentations of alimentary disease.

ADVICE AND EDUCATION

Certainly, the commonest presenting symptom—diarrhoea—may usually be managed expectantly. Numerous consultations result from patients eating too much too soon after diarrhoeal illness, and many others reflect patient experience of receiving unnecessary medication on previous occasions. Simple advice on starvation and intake of fluid will treat most acute episodes adequately—especially in adults. In addition, it forms the basis of encouraging the self-treatment—which most doctors adopt themselves—of future episodes. At the other extreme, non-specific constipation is more healthily treated by increasing dietary fibre than by laxatives, and many patients still need to be convinced that regularity and frequency are not synonyms.

Dyspepsia is as appropriately managed by reducing consumption of chips, alcohol, and cigarettes as increasing intake of alkalis; and the recurrence of haemorrhoids and fissures may be prevented by avoiding constipation. Doctors often complain of the high attendance rates for minor illness of certain patients. How often do they ask if they themselves are in greater or lesser part responsible through having failed to provide necessary health education and by having confirmed the appropriateness of consulting behaviour by prescribing non-essential drugs?

OBSERVATION

Eventually diagnosis, and therefore treatment, depend on identifying recognised patterns of natural history of illness. The more points on the progress of a symptom-sign complex that can be charted, the easier it becomes to define the disorder; the less the interference by drug-taking, the greater the probability that the observations made will reflect the underlying illness and its progress. Thus vomiting that continues is more apt to be caused by, for example, jaundice than is vomiting that stops after four hours; new dyspepsia that persists is more likely to indicate malignancy than is recurrent dyspepsia that remits; alterations of bowel habit may come to be capable of interpretation or—sometimes significantly—may fail to conform to known disease patterns and the acute abdomen, the greatest cause of anxiety to most general practitioners, may develop into clearly recognisable obstetric, surgical, or medical conditions. Active observation[2] is indeed a positive form of treatment.

INVESTIGATION

When it is realised that at least half the disorders of this system are dealt with symptomatically, the importance of knowing when investigation should be part of the management plan becomes axiomatic. Attempts to convert all symptomatic diagnoses to disease diagnoses on the basis of investigation would quickly overwhelm bacteriological, biochemical, radiological, and outpatient resources with relatively small return to the health of the general community or individual patient. The new and apparently increasing range of endoscopic investigations available, together with the possibilities of new and specific treatments becoming available for various conditions not particularly amenable to treatment (such as peptic ulcer), make definition of appropriate rules of investigation hazardous. Is the barium meal examination about to become outdated? Is it correct that general practitioners in some centres should have been discouraged or refused access to barium enema investigation because sigmoidoscopy was thought an essential concomitant investigation? If so why do regional differences apply? What is the place of liver biopsy?

Can we guarantee that when our patients are investigated the number of uncomfortable, undignified, and sometimes frightening procedures in the package is kept to a minimum—and that each is explained fully? At the other extreme, the teaching that management of diarrhoea requires stool culture so patently demonstrates lack of realism that specific investigation of at-risk groups (food handlers, babies, those in institutions, for example) is now often inappropriately neglected, and relevant clinical and epidemiological information is lost.

REFERRAL

The previous section will have hinted at my growing feeling that investigating resistant alimentary problems should normally be carried out (where geographically realistic) by a carefully briefed specialist. Serious alimentary disease is seen too rarely for general practitioners to develop real skill in the use of diagnostic aids, and the consequences of under-diagnosis are important. As well as issues covered in the previous section, referral for rectal bleeding (to be differentiated from anal bleeding) is regarded by many as mandatory; but general practitioners would appreciate a specialist consensus on whether proctoscopy in the surgery is sufficient investigation, or whether hospital sigmoidoscopy should be added routinely for definable groups of such patients.

The acute abdomen—the commonest cause of referral to hospital for *any* general practice condition—must be under specialist supervision when appreciable diagnostic uncertainty is present; but the specialist must be briefed adequately on (and respond constructively to) the many non-physical features that may have material bearing on the long-term handling of the individual patient.

PRESCRIPTION

Few articles make more interesting contemporary reading than that by Dunlop and his colleagues[3] on general practitioner prescribing of over 20 years ago. Then cholagogues, bitters, and antacids were the second commonest group of drugs prescribed. In Patterson's more recent review of general practice prescribing,[4] hypnotics and psychotropic drugs, antibiotics, drugs acting on the respiratory system, analgesics and antirheumatics, and topical preparations were all more often prescribed than gastrointestinal medications—although the range of different preparations used was exceeded only by topical preparations and the combined grouping of hypnotic and psychotropic drugs. The *Monthly Index of Medical Specialties* (*MIMS*) lists 38 antacids, 53 gastrointestinal sedatives, 38 laxatives, purgatives, or lubricants, 22 preparations acting locally on the rectum, and 36 antidiarrhoeals (two-thirds still containing an antibiotic or sulphonamide). The *British National Formulary* (*BNF*) lists a total of 36 formulations to cover all these headings. (An additional 18 preparations for nausea and vomiting are listed in *MIMS* and nine in the *BNF*.)

The range of preparations indicates the widespread use of symptomatic medication and the absence in some cases of specific treatment and in other cases of clear market leaders. As in so many areas of general practice prescribing, personal choice of doctor or patient tends to dominate therapeutic principle.

Some personal policies

SYMPTOMATIC AND SELF-LIMITING CONDITIONS

The three principal illnesses in the symptomatic and self-limiting conditions group are diarrhoea (with or without vomit-

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ing), dyspepsia, and constipation. My view is that, in all three, patient education is the principal therapeutic agent and accordingly explanation and advice dominate my approach to management. Starvation and fluid replacement are the centre-pieces in managing diarrhoea; few people continue to be sick for more than a few hours and really troublesome diarrhoea and colic normally settle quickly. Few preparations probably make much difference to ability to continue at work but when this is a consideration kaolin and morphine may be tried. Antibiotics are *not* part of treatment. Dyspepsia normally responds to diet including bland foods and milk and excluding fats, cigarettes, and spirits. Stress must be identified, discussed, and when possible reduced.

Many patients have their favourite antacid that I would normally prescribe on request; my own choice is usually magnesium trisilicate compound mixture (BPC) or the popular proprietary Aludrox (aluminium hydroxide gel). At present the places of carbenoxolone, the new liquorice and bismuth preparations, and the radically new histamine receptor antagonist, cimetidine, are being evaluated in carefully designed and controlled studies. I would prefer to support these projects by referring appropriate patients to specialists organising the projects (after explanation to the patients) rather than initiate treatment, the results of which can be assessed only subjectively outside proper research protocols. Resistant dyspepsia requires referral; close observation may, however, be needed to allow resistant dyspepsia to be recognised; changing drugs may confuse rather than clarify this important issue.

In its chronic form constipation is often much helped by heeding the message of the bran promoters. Advice to introduce bran to the diet, together with education as to the real range of normal bowel habit, is probably the most constructive approach to treatment. Personally, I recommend laxatives only in the presence of other lesions that may be aggravated by constipation (disc lesions and anal fissure, for example). Like most other doctors, however, I prescribe them much more often than I recommend them.

READILY DEFINED AND INCONVENIENCING DISORDERS

Disorders in the readily defined and inconveniencing disorders category can be comparatively easily visualised and are found principally at the extremes of the tract. Mouth ulcers are uncomfortable and for some patients a recurring problem. Choline salicylate (Bonjela) is an inexpensive and popular remedy for this. Dental infections are most appropriately treated with penicillin by mouth; advice to seek dental treatment is part of proper care, and telephone communication with a dental colleague promotes much useful goodwill.

At the other end of the tract, pruritus ani—remarkably common and most uncomfortable—responds readily to almost any soothing local application, but steroids appear particularly helpful. In treating anal fissure one of several preparations containing steroid, local anaesthetic, and topical antibiotic or antiseptic will provide quick relief. My own particular choice is one of the more expensive of these preparations; I have no good reason for persisting in using it: the name just always comes to mind first, often the true reason for a particular therapeutic choice. Haemorrhoids may be treated similarly, suppositories perhaps being used in conjunction with ointments. The value of ice-packs and raising the foot of the bed, especially when a thrombosis of an external pile is threatening, is also of value. Referral for surgical opinion must always be considered but assessment of individual cases rather than blanket generalisations should be the rule.

UNCOMMON AND LIFE-THREATENING CONDITIONS

Little comment about uncommon and life-threatening conditions beyond that in earlier sections of this review is needed. The unexplained acute abdomen, the possible malignancy, the persisting diarrhoea, and the unexplained jaundice or weight loss are only further confused by dabbling in medication. Consultation (in its true sense) with specialists should be an early policy. Until the need for this becomes evident, careful serial observation is, of course, the best indicator of the range of possible disorders.

Non-physical illness

No view from general practice would be complete without referring to the recurring dilemma of the general practitioner—namely, the need to balance physical disease and its appropriate management against psychological or social illness and its appropriate management. The presentation of non-physical disease in terms of physical disease is a well-known phenomenon of general practice, although doctors vary widely in their interpretation of (and even ability to recognise) different patterns of illness behaviour. Obesity (usually) and weight loss (often) may reflect depression or anxiety, and altered bowel habit and abdominal pain may also be due to psychological rather than physical factors.

Here again my belief—increasingly firmly held—is that prescribing drugs and initiating investigations should not be seen as the automatic first approach to these problems. It is often relatively easy to identify patients for whom planned observation together with a sympathetic but probing interviewing technique should be given a real chance to get behind the headlines. It may be that only when fundamental emotional problems have been identified can effective treatment be planned.

Conclusion

Disease of the alimentary system is important but diffuse. Classification and diagnosis are difficult; thus discussion of management must be more subjective and personal than it might ideally be. Emphasis has been on management strategies rather than on specific disorders and remedies. The review of symptoms, diseases, and treatments is not all-embracing (hiatus hernia, malabsorption, diverticulitis, and other conditions have not been mentioned), but I have tried to develop three main themes.

Firstly, much disease of the alimentary system is best thought of in symptomatic terms and treated by advice and better patient education. The general practitioner needs, however, close (and mutually informed) relations with relevant specialists so that new advances in diagnostic thinking and treatment can be brought to the benefit of the right patients in the most efficient way possible.

Secondly, several readily definable and inconveniencing conditions occur often enough to require the family doctor to be familiar with appropriate policies for their treatment. What the individual doctor chooses will represent a personal choice from a wide (unnecessarily wide, I believe) range of available preparations, some apparently more therapeutically supportable than others.

Thirdly, some diseases with sinister potential are seen too infrequently to allow the general practitioner any reasonable chance of gaining necessary expertise in their investigation or acute management. Consultation, referral, and observation are the appropriate management tactics for these.

References

[1] Office of Population Censuses and Surveys, *Morbidity Statistics from General Practice. Studies on Medical and Population Subjects No 26.* London, HMSO, 1974.
[2] Jones, P F, *British Medical Journal*, 1976, **3**, 551.
[3] Dunlop, D M, Henderson, T L, and Inch, R S, *British Medical Journal*, 1952, **1**, 292.
[4] Patterson, J S, *Journal of the Royal College of General Practitioners*, 1972, **22**, 191.

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