PRACTICE OBSERVED

Law and the General Practitioner

Prescription medicines

STUART CARNE

Under the Medicines Act 1968 all medicinal products fall into one of the following categories:

- General sale list medicines, which may be sold at any shop (and in a few instances from automatic vending machines);
- Pharmacy medicines, which may only be sold by a registered pharmacist;
- Prescription only medicines, which may only be sold by a registered pharmacist on the prescription of a doctor, dentist, or veterinary surgeon (midwives, chiropodists, ophthalmic opticians, and physiotherapists may also prescribe certain of these drugs); or dispensed by such practitioners.

Under the Misuse of Drugs Act 1971 certain "dangerous or otherwise harmful" drugs are placed in the controlled drugs list. They may only be dispensed on prescription and are subject to additional safeguards against misuse (see below).

Writing a prescription

While in theory a prescription for a general sale list medicine or a pharmacy medicine could be written in any form understandable to the pharmacist, in practice all prescriptions written by a registered medical practitioner should conform to the regulations governing prescription only medicines. The prescription must:

- Be typed or handwritten in an indelible ink.
- Give the address and usual signature of the prescribing doctor.
- Give the date on which the prescription is signed or, in the case of a postdated prescription, the date on which it becomes valid.

Goldhawk Road, London W15 8EJ
STUART CARNE, *senior, general practitioner*

valid. Except for certain repeat items, the prescription will remain valid for six months from that date.

— Give some indication—for example, the qualifications—of the prescriber, indicating that he is a registered medical practitioner (or dentist, etc.). National Health Service (NHS) prescriptions form (FP10) have the doctor's name stamped on them and this suffices for identification.

— Give the name and address of the patient and, if under 12 years, the age. (This need only be given to the nearest month for infants under one year or to the nearest year for those older.)

By tradition a prescription also contains the instructions ("Signa") the pharmacist is to put on the label. These are usually written as abbreviations: *ps* (to-ter in the sumendus, post cibum (three times a day after meals)). Previous editions of the *British National Formulary* gave the quantity of non-controlled drugs the pharmacist was to supply if the doctor omitted the amount on his prescription. The latest (1981) edition omitted this. The pharmacist is now encouraged to use his judgment in determining what quantity would be appropriate in such circumstances. It is generally held to be good prescribing to include this information on every prescription, however, either as the quantity—for example, 20 tablets of an antibiotic or 100 ml of a cough linctus—or the number of days the remedy is to be taken. Form FP10 has a space on it for the doctor to write the number of days for which the drug is to be taken. If there is more than one item on the form the use of this box may achieve quite an economy in the physician's writing time as well as a possible reduction in waste because one drug has been prescribed in a greater proportion relative to another. (NB: This "number of days" formula cannot be applied to local applications where the amount used per day is variable; nor may it be used for controlled drugs.)

Provided the signature is that of the prescribing practitioner

*Signa is Latin for label. It may also be an abbreviation for signetur (let it be labelled) or signetur (let them be labelled). The advantage of the abbreviation sign is that it covers all three possibilities.

drug may be repeated without the patient being seen is also stated on the card. When he needs a further supply of one or more items on the card, the patient sends his card to the surgery indicating the items he wants and calls at the surgery to collect his prescription either from the receptionist or, sometimes, from a rack in the waiting room. In some practices repeat prescriptions are posted, though the patient is usually expected to supply a stamped-addressed envelope. If the number of repeats is restricted the patient will be notified when he collects his "final" repeat that on the next occasion he must arrange to see the doctor.

In practices that do not control the number of repeats and a patient is entitled to collect his prescriptions without seeing the doctor there is a risk that some patients will go on taking medication they no longer need or take them in doses which are either too big or too small.

In many practices filling in repeat prescriptions is left to a nurse, receptionist, or secretary. Before signing it, a doctor checks the items against the patient's medical record card or repeat prescription form, or both. There is anecdotal evidence that in some practices the receptionist or secretary is given a supply of blank, signed NHS prescription forms, which she fills in when a patient requests a repeat prescription. (Some receptionists are also said to prescribe for "first events"—for example, cough mixture for a cold or antibiotics for a sore throat—working to a protocol prepared by the doctor, but not having his diagnosis or prescription checked.) There is evidence that there are many errors in prescriptions written by receptionists (and allegedly checked by the doctor).¹ How many of these errors are important and how many are due to clerical errors, such as spelling mistakes, which nevertheless leave the prescriber's intent beyond doubt—is not clear, and further studies are needed.

It has been argued that certain items might be supplied on the NHS by a pharmacist without a doctor's prescription. This would certainly save the doctor's time, but there are snags. From the financial point of view it is difficult to say what control the government would have on this expenditure. At present, by monitoring every general practitioner's prescribing costs once or twice a year a degree of control of these costs can be maintained; what analogous control could there be for prescribing by the pharmacist? Secondly, except for dispensing doctors, the person writing the prescription (the doctor) is not the person being paid for dispensing the drug (the chemist). Even in the case of dispensing doctors, these costs can be monitored against those of non-dispensing doctors.

From the clinical point of view it can be argued that the pharmacist's training does not equip him to make a diagnosis, which most physicians would regard as a prerequisite to prescribing. Nevertheless, pharmacists have always offered advice and often they select a medicine for their customers. ("Can I have something, please, for my 2-year-old son's cough?") To an extent this practice is limited by the fact that such medicines have to be paid for, and in my opinion the cost does provide some control. If it ever came to a choice between the doctor's prescription or a qualified pharmacist deciding what is to be prescribed then the case for the pharmacist prescribing may be more difficult to oppose.

Drug trials

A doctor is entitled in the course of his practice to compare any two (or more) standard treatments. For example, he may compare the use of aspirin with paracetamol in relieving pain, or one *British National Formulary* cough linctus with another *BNF* cough linctus to see which is the most effective under specific conditions.

With a new product a clinical trial is only permitted if the drug is to be tested for a condition listed in the terms of its licence. For example, a new antihistaminic drug may have been approved for use in osteoarthritis. Any physician or group of

physicians could legitimately test that product in patients suffering from osteoarthritis but not in patients suffering from, say, gout. Nevertheless, an individual doctor could carry out a therapeutic trial on an individual patient. Thus, using the example above, a doctor may prescribe the drug for one or more of his patients on an individually named basis to see if it will relieve that patient's gout. If he wanted to conduct a trial in several patients suffering from gout, in which the patients would not receive the drug from an individually named basis, the doctor would have to get (on the DHSS) a Clinical Trial Certificate to obtain a supply of the drug from the manufacturer for use in the trial. Alternatively he could apply to the DHSS for an exemption from holding a Clinical Trial Certificate. This would usually be granted unless the proposed trial posed some hazard, the degree of which could be assessed only by examination of data, such as toxicity or bioavailability. Such an exemption permits a manufacturer to supply the drug for a purpose other than as stated in the Drugs Licence.

So far as a general practitioner is concerned it is more likely that if he is involved in a trial, it would be as a member of a team rather than as an organiser of the trial. In such cases, he must ask himself:

— Is the design of the trial satisfactory? (He may have very limited personal knowledge or experience of these matters, and in practice he will have to go on the reputation of those organising the trial.)

— By putting any of his patients into the proposed trial is he depriving them of the rights or benefits to which they are entitled? This would apply if, for example, he were asked to test a new peptic ulcer treatment against a placebo when it is known that antacids (which are safe) would give the patient some benefit. In testing the new peptic ulcer treatment it must not, therefore, be compared with a placebo but with an accepted alternative active remedy. Using placebos in a trial when there is a known proved active remedy for the condition is in most cases considered unethical.

A common form of drug trial in which general practitioners are asked to participate is that carried out when a new formulation of a product is introduced—for example, the testing of a combined beta-blocker and diuretic. These trials provide an acceptable treatment and therefore do not deprive the patient of any potential benefit. The assumption is that the individual components have been tested and found satisfactory and that their safety factor is known. What the manufacturer—and future prescriber—wants to know is whether this new formulation is an improvement on the individual components.

Legal liability in a clinical trial

Legal liability has never been tested in courts, but it would seem unlikely that a general practitioner could be sued by a patient he has put into a trial, provided he complied with the guidelines above and provided he obtained the patient's informed consent. Should any mishap befall the patient—for example, an unsuspected drug reaction—it is almost certainly the manufacturer who would be responsible (and who would, anyway, have insured himself against such an event).

Much publicity has been given to a proposed EEC regulation that should a patient suffer any harm from using a prescribed medication the physician who wrote the prescription would be liable to compensate the patient. There is some argument whether, if the drug were a proprietary preparation, the manufacturer would be responsible and not the physician, but none of these issues have yet been resolved. The present position is that if a patient suffers any damage from a properly prescribed drug he would only be likely to succeed in a claim for damages if he could prove that the product was of faulty manufacture—that is, some error had crept into the manufacture of one or more batches, causing the drug to be harmful.

The appearance of an allergy to a drug is not, under present

and is an "original," the remainder may be written (or typed) by a deputy—for example, a receptionist—or be a carbon copy of the original, except in the case of a controlled drug, when the following further restrictions apply:

— A prescription for the drug and the name and address of the patient as well as the doctor's signature must be in the doctor's own handwriting and be a copy (neither typewritten nor carbon copies are permitted for controlled drugs).

— The form of the preparation—for example, tablet, capsule, linctus, injection—must be written on the prescription and, where appropriate, the strength must be given in both words and figures; so too must the total quantity of the drug to be dispensed or the number of dosage units, as the case may be.

A prescription, whether NHS or private, is valid for six months (13 weeks in the case of a controlled drug) from the date the prescription was signed. Provided that the first dispensing of a repeat prescription was within the six months, the subsequent prescriptions may be dispensed at any time, though after a very long interval the chemist may want to check with the prescriber that his intention remains.

Repeat prescriptions

The role of the repeat prescription and its importance in the doctor-patient relationship is complex.¹ Many patients are on prolonged courses of treatment, sometimes indefinitely; once started on a remedy a few continue to take the same medication for the rest of their lives although the dose may vary with time and monitoring will be necessary—for example, thyroxine.

Providing patients with repeat prescriptions—that is, arranging for a further supply of a previously supplied medication without the patient having to see the doctor—is a universal custom: it is not just a British practice. Where the practice does differ it is that under the NHS the doctor's prescription enables the patient to get a medicine either free of charge or at what is usually a very reduced rate. Thus many items which would in other countries (or by private patients in Britain) be bought over the counter without a prescription—for example, antacids—will on the NHS be obtained on prescription because it is cheaper for the patient, though for those not exempt from prescription charges—presently £1—some items may now cost less if purchased over the counter.

Often the patient on a repeat prescription has an illness which though not lethal is incurable—for example, asthma, eczema. Changing treatment of control is rarely beneficial. Once such a regimen has been found, the patient can learn to manage his own illness. Thereafter he will need repeats of his medicine and since his doctor will have to supply any necessary prescription to enable him to get them, it is clear that some way of providing repeat prescriptions will be needed. For the patient with a chronic disease the problem is not whether the medication should be continuously prescribed but at what intervals the patient should be reassessed and how he is to obtain medication in the intervening period. Difficulties may, however, arise when the patient tries—and sometimes succeeds—in getting a prescription for a new symptom or a change in an existing symptom without actually seeing the doctor. The repeat prescription is now acting as an alternative to a proper medical consultation.

There are various reasons why a patient should continue to take a prescribed medicine:

- (1) Those having long-term prophylactic medication—such as an oral contraceptive. Once established on a suitable pill further examinations are only needed at 6- to 12-month intervals.
 - (2) Those having endocrine replacement treatment—for example, hypothyroid patients and diabetic patients on insulin.
 - (3) Those having other continuous long-term drug treatment—for example, epileptic and hypertensive patients.
- Some also include in the definition drugs prescribed for patients who are having intermittent but usually long-term treatment—for example, patients with dyspepsia and those who

suffer from migraine. Some extend the definition to include drugs prescribed for acute exacerbations of a chronic illness—for example, chronic bronchitis—and even for recurrent infections. I am sometimes phoned by a new patient who asks if I would leave a prescription on the shelf for an antibiotic "because the child has another attack of tonsillitis or otitis media." The parents seem surprised—but usually pleased—when I reply that I prefer to examine the child each time before prescribing a fresh course of antibiotics however often the child has had it in the past.

There are also patients who attend a specialist clinic at hospital, at regular but often infrequent intervals, who expect the general practitioner to prescribe the hospital-initiated drug in the intervals between outpatient appointments. Many hospital doctors make the same assumption, particularly since the recent cuts in hospital expenditure. It has long been the policy of the Department of Health that the doctor who decides the treatment should write the prescription. Furthermore, the doctor who writes the prescription must remain, at least in part, responsible for any harm that might befall the patient: a lot will depend on the acceptability or otherwise of such treatment. (So far as NHS prescribing costs are concerned, it is only a limited defence for a general practitioner whose prescribing costs are being questioned to say that what he prescribed was on the advice of a specialist.) If an NHS patient sees a specialist privately he may ask his general practitioner to rewrite the specialist's prescription on an NHS form. Provided that the general practitioner referred the patient to that specialist, it would be reasonable for the patient to have his drugs on the NHS so long as the general practitioner has vetted them for cost effectiveness as well as safety. It would not be reasonable for a patient to have a more expensive preparation on an NHS prescription merely because it was recommended by a private specialist. If the general practitioner is of the opinion that there is an alternative and cheaper drug that is equally effective.

Except for controlled drugs, the prescriber may indicate on a private prescription that the drug may be repeated once, several predetermined times, or as often as wanted either at specific intervals or as and when the patient wishes. Under the existing NHS regulations, this facility is not available. The FP10 is not only a prescription, it is also a voucher against which the pharmacist will be paid by the NHS for supplying the drug. Under the NHS, if a prescription is to be repeated the doctor has three alternatives:

- (1) The patient may have to see the doctor every time he wants a further prescription. This should normally only be necessary if a potentially dangerous drug—for example, a controlled drug—is being prescribed.
- (2) The doctor may issue a patient with an additional postdated prescription form for the same item, either carbon copies (except for his signature) or additional "top" copies. For example, a patient might see a specialist privately for 28 days' supply of a drug and two further prescription forms for the same drug and for the same period but dated 29 June and 27 July respectively.

A few practices confine their repeat prescriptions to these postdated copies: no patient can have a further supply without actually seeing the doctor. These doctors claim they exercise a greater control over their treatment and avoid patients concealing the development of new symptoms.

(3) In most practices arrangements are made by the doctor for his patients to call (by telephone, letter, or in person) at the surgery and collect (or have posted or delivered to them) a further prescription when the previous supply is running out. Many practices have introduced various forms of organisation that ease the burden of this work, regulate the flow, control possible abuse, and even perform some sort of audit.

There are a number of repeat prescription cards (produced either by individual practices or by pharmaceutical companies) in which the doctor writes the name of the drug(s) that may be repeated and the dose and the quantity to be given on any one time. Often, but by no means always, the number of times the

law, grounds for using a manufacturer unless he is aware of the risk and has failed to disclose it to those who prescribed the drug. Similarly a doctor who prescribed a drug to which a patient developed an allergy could also not be held liable if it could be shown that he had been negligent by failing to take reasonable precautions. For example, he had not asked the patient before prescribing penicillin whether he had previously had any known reaction to that antigen or whether he had been identified during the early stage and hazards may not come to light until after the product has been in general clinical use for some time—for example, thalidomide and practolol. Whether the manufacturer

Unemployment in My Practice

Waterlooville

K B THOMAS

The area my practice is in has not had an unemployment problem over a long period of time, nor has it ever been a severely affected part of the country. Indeed, only in the past few months have we reached the national average of 10% of people out of work, and it would be wrong to suggest that the practice is obviously distressed by this trouble. There are, however, unmistakable signs that things are not quite as they were. The old confidence, the feeling that everything is possible, that everything is within reach, that each of us is the focus of a benign beneficial organisation has gone. The threat of unemployment lies like a pale shadow across the practice.

One of the first things I noticed was that some patients were reluctant to come off work. This is exemplified by the case of a gentleman who is much better known to me than I would wish. He used to burst into my room without knocking, with the words, "It's gone again, Doc." I always asked, "What's gone?" although I knew perfectly well. And he would reply, "My back." Then, after a negative examination, I would mention the subject of work. He would purse his lips and inhale a volume of air audibly, while half closing his eyes. His expression was a mixture of incredulity, sadness at the thought that I should expect him to work, and pain at the idea of actually performing it. A moment later he had taken my proffered certificate and departed with agility through the door—he was never interested in treatment. He came to see me recently, not because of his back but with a cough and cold. I was surprised; he even looked ill. I examined him and gave him a prescription. Then there was a pause as I waited for him to ask for a certificate. He was looking at me with a faint wistful smile that was almost apologetic, regretful that he could not fulfil his traditional role. I felt a little sad, and perhaps this showed in my face. I think the episode is what my colleagues of the left would call non-verbal

communication. At all events we understood one another. For so long I had been able to supply his needs, and now the rules of the game had been changed.

These are bad times

Often as an undercurrent or as background one learns that the patient or his wife or her husband is unemployed. I was told by one wife how restless and irritable her husband has become since he has been at home; by a teenager that she is quarrelling with her parents because "I cannot go out now; I've no money." Some young people get into more serious financial difficulties. In one family the husband, who had been unemployed for three months, could not face the mounting bills and attempted to end his life. Yet most people I talk to are philosophical: "These are bad times," they say, "and I am not the only one."

What disturbs me most as I roam round the practice is to find, perhaps in the afternoon, a young man sitting watching television. "Hello, what are you doing at home?" I ask, and back comes the answer, "I am out of work." Thinking and feeling not as an economist but as a doctor who has been in the practice so long that I might well have known this man all his life, I find it so absurd that he is being paid for doing nothing that I can hardly believe that it is true. He would be better off being something with other people digging holes and filling them in again. He would be better off physically, physiologically, and socially—to borrow a phrase from the Royal College of General Practitioners.

Work is such an important part of our lives that if there is to be no work for some people, and I fear that full employment may never come back, then work must be created, perhaps second-class work at a lower rate of pay. To have a large section of the community doing nothing for a long time is a certain recipe for disaster, disaster for the individual and perhaps disaster for society. A patient told me that her husband, who was epileptic and had been unemployed for a long time, had attacked her. "You see," she said, "he has nothing to do all day now. He used to have to go once a week to draw his money, and this took him out of himself, but now they send it to him by post."

Waterlooville, Portsmouth, PO7 6AH
K B THOMAS, *MD, General Practitioner*

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Unemployment is only one manifestation of our disintegrating society. The general practitioner, with his finger on the pulse of the people, is in a good position to observe the change that is taking place—economic, social, psychological, and spiritual change—change that we can barely recognise in our society. There is perhaps some consolation in the thought that this has happened before. Barbara Tuchman in her book *A Distant Mirror* compares our present plight with the "violent,

Sex Problems in Practice

Premature ejaculation

ELIZABETH STANLEY

Definition

Premature ejaculation has been defined in many different ways, such as when ejaculation occurs before or within 30 seconds or two minutes of vaginal penetration taking place, or after less than 10 intravaginal thrusts of the penis. Masters and Johnson¹ were the first to consider the woman in its definition and suggested that the man was a premature ejaculator if he did not last long enough for the woman to reach orgasm during intercourse on 50% of occasions, although acknowledging that this definition would not be appropriate if the woman was non-organic for reasons other than premature ejaculation. Essentially, however, premature ejaculation is the absence of voluntary control over the ejaculatory reflex, regardless of duration of penetration, number of thrusts, or frequency of the partner's orgasms.

Presentation

Premature ejaculation itself is usually the presenting complaint, but sometimes it is impotence instead and only on careful questioning does it emerge that the real problem is ejaculation occurring with little or no erection before penetration can take place. At other times true impotence is the problem but turns out to have had its origins in past premature ejaculation. In some women who present with lack of sexual responsiveness or failure to achieve orgasm, or both, their partner's inability to control ejaculation may emerge as the main contributing factor. There are even men who are unaware that "coming" very quickly can be a problem, and actually regard it as a sign of their virility.

Organic causes

As with all sexual presenting symptoms, organic causes (although rare with premature ejaculation) must be excluded before psychological ones are considered. Particularly when ejaculatory control has previously been good, any neurological disorders or localised genital pathology such as prostatitis need to be excluded.

Departments of Obstetrics and Gynaecology and Psychiatry, St George's Hospital Medical School, London SW17 0RE
ELIZABETH STANLEY, MSc, LMC, lecturer in human sexuality

tormented, bewildered, suffering, and disintegrating age of the fourteenth century, a time, as many thought, of Satan triumphant."

And what can we do about it in the practice? Little enough, I am afraid, and yet the general practitioner, although he has changed and his system of medical care has changed, may well have retained a function which he has had for a thousand years, of being someone to whom the patient can turn in adversity.

Psychological causes

Freudian theory postulates that the premature ejaculator harbours unconscious but intensely sadistic feelings towards women; the unconscious purpose of rapid ejaculation is to defile and so to deny, incidentally depriving her of pleasure. Masters and Johnson¹ contend that early sexual encounters under stressful conditions when unwanted discovery is always imminent—such as making love in the back seat of a car—are predisposing factors, as are experiences with prostitutes whose only aim is to get on to the next customer as quickly as possible. None the less this does not explain why only a proportion of men with these types of early experience subsequently develop premature ejaculation. Marital problems can undoubtedly contribute to it or cause it, but often resolving the marital conflict alone does not alleviate the premature ejaculation. Some believe that anxiety is the basic problem and others that there is excessive sensitivity to erotic sensation. The explanation most closely in accord with my own clinical experience, however, which is the antithesis of the last viewpoint, is that put forward by Kaplan.² She says that the crucial aspect of the problem is that the man has failed to allow himself to receive the sensory feedback of those sensations that occur immediately before orgasm which would enable him to bring his ejaculatory reflex under voluntary control. She compares the process to that of a child gaining voluntary control over bladder function, which cannot be achieved without the child first appreciating the sensation of a full bladder, and points out how any organic impairment of sensation from the bladder results in loss of voluntary control over its function. Likewise, she suggests that lack of awareness of pre-ejaculatory sensations prevents a man from bringing his ejaculatory reflex under voluntary control. Indeed, once intensely aroused many premature ejaculators lose all awareness of erotic sensation and develop a kind of genital anaesthesia.

Principles of treatment

Psychoanalysts have believed that the only effective treatment was prolonged analysis in which other than sexual processes thought to underlie premature ejaculation are uncovered and resolved. Usually "first aid" measures, such as thinking about income tax returns or biting a lip painfully hard, have been tried to distract the man from thoughts of the strength and intensity of his erotic sensations. Unfortunately these seldom work, and

his penis firmly for 15 to 20 seconds with her thumb placed on the frenulum and her first two fingers on the other side of his penis, just above and below the coronal ridge. The pre-ejaculatory sensations will then be lost and the erection may diminish slightly. Stimulation is then resumed and the squeeze reapplied when orgasm is again thought to be near. This procedure is repeated three or four times after which the man may ejaculate if he so wishes.

It is emphasised that at no point should the man try to exert voluntary control over his erection, but rather to signal to his partner to stop stimulation, as this would defeat the object of this exercise. Instead he is encouraged to focus on the good feelings he is experiencing in his penis, which often provokes the response, "But that's the exact opposite of what I thought I should be doing!" In subsequent sessions a lubricant such as KY jelly may be used to simulate the sensations produced by the woman's vaginal secretions, and the squeeze may be abandoned in favour of simply stopping and starting stimulation. This procedure should be repeated daily, or as nearly as possible, until the time between starting stimulation and feeling the desire to ejaculate has increased appreciably, at which time the couple can proceed to the next stage.

SECOND STAGE

General body pleasuring should be repeated, and then, with the man lying on his back, the woman kneels astride him, leaning forward slightly so that an insert his penis into her vagina and gradually move backwards on to it. To begin with she does not move so that he can get used to the simple but immensely pleasurable sensations of being still inside her vagina, feelings he has not often appreciated before. If he feels he is near to ejaculation he tells her, and she rises up off his penis and waits until this sensation diminishes. If wished, the squeeze may be applied at this point with the woman holding his penis against her vulva. Penetration is then resumed, and the woman gradually moves up and down on his penis until he signals her to stop. As he gains increasing control he gradually starts to make thrusting movements himself, stopping and starting as sensations dictate. This is repeated three or four times in any one session, after which he may choose to ejaculate. Again this needs to be repeated daily if possible, and as the man gains further control he may simply slow down his thrusting instead of stopping each time he feels the need to ejaculate. Kaplan recommends using the "stop-start" technique in the lateral position before moving to the male superior position; although I do not usually find this necessary, it nevertheless can be an enjoyable position to introduce to the couple. If only the squeeze technique is used throughout it must be explained that when normal intercourse is resumed thrusting will always need to be regulated to some extent to avoid ejaculating before it is desired. It is important to clarify that the squeeze does not physically hold back the semen, but only aids in the recognition of the pre-organic sensations.

If these techniques are used regularly voluntary control over ejaculation is usually achieved in a few weeks, although the techniques may need to be repeated at intervals over the next few months. The enhanced level of communication that also results from the "homework" is an added bonus, often improving the general quality of that couple's relationship in an unexpected and delightful manner.

References

- Masters WJ, Johnson VE. *Human sexual inadequacy*. London: J & A Churchill, 1970.
- Kaplan HS. *The new sex therapy*. New York: Quadrangle New York Times Book Co, 1979.
- Kaplan HS. *Disorders of sexual desire*. Baillière Tindall, London, 1979.
- Stanley E. Principles of managing sexual problems. *Br Med J* 1981;282:1200-2.
- Stanley E. Dealing with fear of failure. *Br Med J* 1981;282:1281-3.

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Profiles of Practices

No two alike

KEVIN ILSLEY

It's fashionable to criticise vocational training and question its relevance to everyday general practice, so I hesitate before admitting that I have enjoyed my trainee year and found it instructive. I suppose that living in a pleasant part of the country helps. From a distance Malvern looks strangely un-English, clinging as it does to the slopes of the Malvern Hills. Yet it is the most English of towns, with an air of faded elegance. It was once famous as a spa town but now is better known for its many schools. The population swells by the thousands in term time, giving some practices a lot of extra work—and, of course, extra income. A large proportion of the population is elderly; many of the large Victorian and Edwardian family houses now serve as nursing homes and people still retire here, attracted by the scenery but curiously underpinned by the steep streets. Almost 20% of the practice's 7500 patients are over 65 years of age.

There is a little light industry in the town—the marvelously anachronistic Morgan sports car is made here—but the Ministry of Defence is the largest employer. I was surprised to find so many doctors on the practice list before I realised that they were PwL research scientists at the Royal Signals and Radar Establishment, which seems to employ thousands. There is no other large employer, but many people commute to Worcester or to Birmingham.

The town attracts many visitors. Hordes of people tramp the hills, and the recently revived Malvern Festival brings people into the town during its two-week Spring run. The Festival ensures the viability of the theatre, which gives the practice an added interest—it is on call for any emergencies and a routine day's calls are sometimes relieved by having to treat, for instance, a ballerina's sprained ankle or a singer's strained throat. The town is well served medically, with three group practices and three single-handed doctors. There is a small hospital with x-ray and physiotherapy facilities at the disposal of general practitioners, a GP-run casualty department, and 18 medical and surgical beds.

My country practice

The three partners in my training practice rebuilt their own premises a couple of years ago. It is a pleasant, one-story building, set back from the road—one of the leafy avenues that run from the centre of the town. A glass-fronted receptionist's office looks out on to a small entrance hall from which patients are directed to one of the three waiting rooms that are attached to the partners' consulting rooms. Trainees are something of an afterthought, and "my" room doubles as a treatment room used by the two attached community nurses and the health visitor. There is a practice manager, who shares a spacious office with a

Malvern, Worcestershire
KEVIN ILSLEY, MR, MRCGP, general practitioner

couple of secretaries. It is a friendly practice. The doctors get on well with each other and are on first-name terms with the staff, and I was made very welcome.

Though the three partners get on well with each other they are all very different. My trainer is in his late forties, a trained psychiatrist and psychotherapist, who not surprisingly tends to adopt a psychotherapeutic approach to problems. The senior partner has been in the practice longest but is 10 years younger than my trainer. He and the third partner, who is about my age (that would be telling), have a more system-orientated, organic approach—a combination that I think I feel works to the patients' advantage since they can choose which doctor they want to see, and they seem to select the partner most suited to their needs.

I am sure it has been an advantage to be the first trainee in the practice. Some of my friends think that the trainee label affects their relationship with patients, who realising that they are temporary tend to present only short-term problems. But I felt that I was treated as just another doctor by patients and staff alike and was exposed to a broad spectrum of practice. I was pleased that I didn't have to cope with the disadvantages faced by one of my friends who found a notice in his waiting room that read, "Doctor X is a trainee general practitioner attached to the practice for one year. Please co-operate and agree to see him if asked to do so."

Malvern presents a middle-class face, and I wasn't surprised to find a large number of professional and business people among the patients. But there are areas of social deprivation here, too, and we have our share of social problems—though I am not sure that problems are necessarily confined to a particular social class. The practice has a higher-than-average home visit rate, probably because there are so many elderly people on the list. Most of the patients are drawn from the town, but even when driving round the town the countryside there is a pleasant distraction, the hills but a glance away. Enough patients are in the surrounding countryside to make rural cases a commonplace, and I enjoy getting out of the town—pleasant though it is—and tramping round farms for a change.

An inner-city practice

I have been encouraged to get out to look at other practices—maybe my trainer's been trying to tell me something? He used to work in London and arranged a week's exchange with the trainee in his former practice. I was quite happy in Malvern but found myself overcome with a masochistic urge to see what life was like in an inner-city practice.

The differences between the two practices were jarring; the many similarities took little longer to register. Whereas the Malvern practice premises were owned by the partners, my three London hosts shared part of an enormous, impersonal modern health centre with two other practices, dentists, health visitors, and radiologists and upstairs the department of general practice of one of the London medical schools. Instead of easy

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waiting rooms there was a large open-plan waiting area designed to be shared by all patients—sensible use of space. Not all "senior" ideas work though, and the practice had managed to get permission to convert a room that was closer to their consulting rooms into "their" waiting room, giving the practice a separate identity that I think must have lacked before.

Though the premises were different I found that the staff had much in common. I was warmly welcomed by the reception staff, who seemed amused at the idea of a "country trainee" coming to the big city. The partners were friendly, relaxed and quickly put me at ease. There were two male partners and one "lady doctor," who all seemed to get on well together. During the week I was impressed by their medicine and their sympathy for patients, and by the way they handled the "hard doctors" who are supposed to inhabit the murky recesses of inner cities. In the consulting room it was difficult to see what difference there was between inner city and country practice. True, the patients' stories were different. I found that the problems were presented and dealt with in much the same way that I was used to. But I noticed that there were fewer elderly patients and more single people without any local family support. Away from home the patients seemed to have a more earnest talk about the problems of social isolation and discussion about the role of the primary health care team. When was intervention appropriate? Should there be a scheme to introduce isolated pregnant mothers to each other for instance? This was all rather alien to my appreciation of practice at home where social problems certainly existed, but where there was still some vestige of community and family support.

Outside the practice there were more striking. It could hardly have been nearer the centre of London, lying as it did half way between Euston and Paddington amidst a jumble of decaying Victorian buildings and modern tower blocks. Most of the patients lived relatively close to the practice, though distance is meaningless in London. I had forgotten the frustration of inching through London traffic, all the more frustrating when trying to visit a patient who according to the map lived a mere car hop away. Then to find patients in obscurely numbered flats, in identical-looking, idiosyncratically-named tower blocks.

Maybe it would have been easier with time. What I don't think I would ever have found easy is dealing with London hospitals. We are fortunate in Malvern to enjoy good relations with the local hospitals where most of the consultants are known personally to the general practitioners. The voices at the end of the London telephone were impersonal, unhelpful—did I sound so pompous when I was a houseman in London? I was reminded of the teaching hospital role that general practice medicine is second-class medicine, city general practitioners are best incompetent and at worst dangerous, to be kept at arm's length. I was conscious of a great gulf between the hospitals and the community they served—a subjective reaction and perhaps unfair after only one week's exposure to one London practice.

The surgery in Malvern was no more than 10 minutes away from any of the partners' houses. At the end of the London day the surgery was locked and the partners went their separate ways, joining other commuters on their way to the outer suburbs. I imagine it's difficult to live close to a central London practice because of property prices, but none the less I was left feeling that it was more difficult to practise a high standard of medicine when doctors live at a distance from the area they serve. It was a pity that I was not in London for longer. I now know that I would find it extremely difficult and frustrating to work in inner London. But at the end of the week there I felt nothing but admiration for those doctors, who seemed actually to enjoy working there and to deliver a high standard of care in difficult conditions.

Private medicine

Before I left I had the opportunity to watch a private general practitioner at work. I went to South Kensington intending to be

critical. I am unhappy with the idea of private practice and conjured up an image of a smooth operator interested only in making money out of his unfortunate patients. But posturing seemed inappropriate once in the practice—a converted basement in a residential block. I was bowled over by the enthusiasm of this particular general practitioner. He worked with a manic energy, finding time between patients to lecture me on the evils of the National Health Service. Yes, he had worked as an ordinary general practitioner for 12 years before coming to the conclusion that the system was wasteful, inefficient, and stifling. There was no incentive for general practitioners to practise good medicine—indeed pay rises came regardless of the quality of care provided. Lack of equipment and surgery facilities meant expensive, unnecessary referral to hospital specialists, and the carried out investigations and procedures well within the competence of the average general practitioner. Should he dig into his own pocket to improve his surgery and widen the range of services he is able to offer, his enterprise goes unrewarded. Sloth and inactivity are encouraged—the message ran—and the most energetic thing the average general practitioner does is write prescriptions.

He was certainly a persuasive preacher and almost had me converted. I was impressed by his surgery with its x-ray equipment, pathology lab, electrocardiograph, audiometer, and staff to run it all. There was a physiotherapist, a lab technician, practice nurse, secretaries, and, of course, an Arabic interpreter. But the clientele was by no means exclusively foreign. There was a very brisk demand from ordinary Londoners, apparently as dissatisfied with the NHS as their doctor was, who were more than willing to pay the modest fees. The whole enterprise was paid for out of fees, but I don't understand why they were not higher than they were. Perhaps it was possible because the working day was so long, running well into the evening and finishing with a session with visiting consultants who provided second opinions. I am not sure where the elderly, the frail, or the handicapped fitted into such a system but was impressed in spite of myself by the quality of the care that was delivered. I was left wishing that this brand of extended primary care was feasible with the NHS.

I'm not sure that I have learnt any more medicine in my trainee year than I would have done had I joined a sympathetic practice as a partner instead. But the year has made it possible to take a broader view of practice. I have enjoyed visiting other practices and have a much clearer idea of the sort of practice I would like to work in. My only problem now is to find it.

Domiciliary problems

One of the critical things when you get a consultant out to do a domiciliary visit is that you must make certain that the patient tells him the story they told you. I once saw a middle-aged woman who had been vomiting and obviously ill for three weeks. Those were the days when you couldn't get quick outpatient appointments, and basically she needed a barium meal. I called out a senior consultant, a remarkable man who had been in general practice, saw the woman the day before and I examined her. The consultant came and he could see, as I could, that she was pretty ill, and he said to her, "Well my dear, what is it that has been the trouble?"

She replied, "Well, doctor, it's these lumps on the back of my head." He put his hand there, and he felt the bony secondaries. I'd been going in there for three weeks. She was my friend of mine, and she hadn't once mentioned it to me. As we went out the consultant put his arm round my shoulder and said, "Ken, don't worry, it happens to us all"—KEN DIXON, general practitioner, Birmingham.

We will be pleased to consider for publication other interesting stories about general practice.—Ed, BMJ.

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the reason why can readily be understood if Kaplan's theory of causation is accepted. Other tactics that aim to diminish sexual sensations and delay the onset of high levels of arousal include the use of condoms, alcohol, sedatives or other drugs, and anaesthetic ointments; but these are not to be recommended because if they work at all they do so for only as long as the particular agent remains in use. Masturbating before intercourse takes place and behavioural techniques aimed at reducing anxiety are two other approaches that seem to have only limited effectiveness.

The two most successful methods of dealing with premature ejaculation are the "squeeze technique" described by Masters and Johnson¹ and the "stop-start" method evolved by Kaplan.² Both are based on a technique developed in 1956 by a urologist, James Semans. Central to their success is the fact that both methods repeatedly focus the man's attention on the sensations immediately preceding ejaculation. They are, in effect, techniques of "biofeedback" similar to those used to regulate automatically controlled bodily functions such as pulse and blood pressure, hitherto thought to be beyond voluntary control.

Both the "squeeze" and the "stop-start" techniques seem to be equally effective as each carries with it the same essential ingredients. I personally combine the two in a modified form, preceded by the treatment strategies of education, "permission-giving," and facilitating communication that are mentioned elsewhere,³ and have not yet had a treatment failure. In young couples and in couples with a basically sound relationship however, use of the squeeze or stop-start alone may be all that is required and these measures are likely to be all the treatment that is needed, and they could easily be used in routine general practice. With some couples, however, resistance to treatment may be met, often at a point when progress is becoming apparent. This unconscious sabotage may declare itself in many different ways, such as the man bringing home mountains of work from the office, or the woman finding excuses to avoid doing the "homework." Often merely interpreting this process to the couple is enough for the treatment to proceed. Sometimes, however, such resistance may reflect deeper underlying problems hitherto unrecognized, in which case it is necessary to clarify and resolve these problems before continuing the treatment for premature ejaculation. This may be more time consuming than is compatible with general practice, and many may feel that they have insufficient skills to continue at this point. If the couple is then referred elsewhere it is important to assure them that the treatment has not failed but has brought to the surface other problems that require specialist intervention.

If the woman also has her own sexual problems it is important to explain that she will not be forgotten, but the first and possibly the only step required for their resolution is to deal with her partner's premature ejaculation. If necessary, though, treatment strategies described elsewhere³ may be used subsequently to help resolve her problems.

Treatment procedure

FIRST STAGE

The couple is asked to set aside plenty of unpressured time for the "homework," which begins by the couple caressing each other's bodies in ways that are regarded as mutually pleasurable. More structured "sensate focus" exercises may be given if preferred. The man is then asked to lie on his back, as relaxed as possible and with a passive frame of mind, thinking only in terms of receiving. The woman then proceeds to stimulate his penis until he feels he is near to reaching a climax. Masters and Johnson¹ describe the point of ejaculatory inevitability (put more simply by one of my couples as "the point of no return") after which ejaculation will occur regardless of almost any circumstances. The man needs to become aware of this point, and just before it is reached he signals to his partner to stop the stimulation. In the early stages I usually suggest that she also squeezes