and critical of medical management than the rest of those in the study. Only four of the 12 thought that they did not know enough about asthma, though nine did not think their doctor's explanation adequate. Seven did not see medicines as recommended and 10 had sought information from other sources.

"FAILURES"

At the end of the study 17 patients were considered by the research worker to still be severely disabled by asthma. Table VII shows that in 14 the asthma had been graded by the doctor as mild to moderate. There is some discrepancy between the drug treatment recorded by the doctor and that reported by the patient. Perhaps doctors underestimated or patients manipulated their own drug regimens. When patients reported using more drugs than recorded it is likely that doctors failed to write down amended treatment.

Five of these patients, all female, were severely asthmatic according to both disability and peak flow recordings. One, a child on oral steroids, attended a hospital outpatients department regularly and

TABLE VI—Views and behaviour towards asthma expressed by patients at first and final interviews

Patient's views	Percentage of patients aged under 15 (n=42)	Percentage of patients aged 15 and over (n=32)	Total (n=74)
(1) Do not think they know enough about asthma	44	49	55
(2) Do not think doctor's explanation adequate	45	40	42
(3) Do not feel their asthma is under control	64	62	63
(4) Do not take medicines as advised	50	46	48
(5) Do not feel uneasy about taking medicines	36	38	37
(6) Do not feel uneasy about taking medicines	15	40	30
(7) Do not feel uneasy about taking medicines	36	41	36

TABLE VII—First interview: views and behaviour of patients related to disability

Patient's views	Percentage of patients aged under 15 (n=23)	Percentage of patients aged 15 and over (n=11)	All patients (n=34)
(1) Do not think they know enough about asthma	26	71	44
(2) Do not think doctor's explanation adequate	39	63	59
(3) Do not feel their asthma is under control	22	54	32
(4) Do not take medicines as advised	17	13	47
(5) Do not feel uneasy about taking medicines	22	34	42

TABLE VIII—Severity of asthma at final interview, treatment as reported by doctors and patients, and doctors' assessment

Treatment	Disability grade III (n=17)	All interviewees I or II (n=45)
Doctors' assessment		
Severe	4	1
Moderate	13	2
Mild	10	42
Patients' assessment		
Severe	4	1
Moderate	13	2
Mild	10	42

*Five unrecorded.

the family considered that the hospital was mainly responsible for the management of her asthma. The remaining four were adults, all graded as mild to moderate by their doctors; one reported treatment, one bronchodilators only, one regular sodium cromoglycate, and one inhaled steroids. The management of these patients, whose condition did not improve during the study, seems to have been less than ideal in three ways: (a) the failure of communication between doctor and patient, possibly leading to (b) poor assessment by the doctors, possibly leading to (c) the inadequacy of the treatment prescribed.

Discussion

The results of our study suggest that family doctors can agree on a management plan for their asthmatic patients and put it into practice. Cards were filled in and patients who had not been seen were recalled and their treatment reviewed. Patients with asthma were aware that interest was being taken in their care, and active and continuing participation in the study enhanced the doctors' interest. Thus during the year 66 new asthmatic patients of all ages were added to the disease register (but not included in this study). Change of behaviour by the doctors was shown, but we cannot say whether this is permanent or not.

According to our indicators of asthma severity "improvement" after a year was most noticeable in those aged under 15. This may be partly due to parents insisting that the child follow medical advice. Furthermore, asthma in childhood is more amenable to treatment and tends to improve with age. In wheezy children are only mildly affected, and over half of these will have stopped wheezing by the age of 21.⁴

Improvement was less noticeable among the adults. There is a general feeling, especially among many of the most severely affected patients, that they did not have sufficient knowledge of asthma and that their symptoms were not adequately controlled. Half of the adults did not take their medicines as advised and a fourth had tried non-medical treatment such as acupuncture, homeopathy, and relaxation techniques, which may indicate a failure of conventional medicine or a lack of conviction that their own doctor could help. People who continue to be severely affected by a chronic disease that in others is clearly under control are bound to question aspects of their medical management.

What effect has the management plan had on patient care? Although our measurements showed an overall improvement in the severity of asthma, it was impossible to establish causal links between the doctors' changed behaviour and patients' health. Perhaps future studies of this nature would benefit if preceded by two years of observation of existing care of asthmatic patients.

Perhaps the most noteworthy feature of this study is the range of discrepancies shown. Discrepancy exists among the three indicators of asthma severity, between the views of doctors and patients about what is an adequate explanation, and between the doctors' and the interviewer's assessment of severity. We assumed that the research worker, who saw patients for about an hour each time, made a more valid assessment of the severity of the patient's disease than the general practitioner, who made a quick, often intuitive, decision at the end of a relatively short interview. A discrepancy was evident between how patients perceived their physical condition and the results of lung function tests. This finding agrees with Rubinfeld and Payne,⁵ who found that 15% of 82 patients assessed were not aware of severe airflow obstruction. Assessment by patients of how severely they are affected by their asthma depends on many personal, environmental, and social characteristics including powers of recall, age—"It doesn't affect me at all, I wouldn't want to run around at my age"—life-style, and occupation. In a patient in a sedentary occupation daily symptoms may perhaps be managed without time ever being lost from work. Alternatively, in a patient who has a physically strenuous occupation relatively minor symptoms may result in days off from work.

Interesting GPs of the Past

Samuel Taylor Chadwick: 1809-73

IVOR FELSTEIN, NASIM NAQVI

In Victoria Square, Bolton, Lancashire, a magnificent bronze statue with the simple legend CHADWICK looks down on contemporary passersby. Set boldly alongside the town hall, this memorial to a local nineteenth century family doctor was erected by the townspeople in the name of Chadwick's surgery. The statue was paid for from funds contributed by over 20,000 citizens of the town, and over 30,000 attended the unveiling. Few general practitioners in any era can have inspired such admiration and respect from ordinary working citizens in their town. For a whole town to honour a family doctor in such lasting fashion his role in their health, welfare, and everyday life must have been outstanding.

Sam Chadwick did not reach Bolton until he was 14 years old. He was born in 1809 at Newcroft House, a family farm in Urmoston, Manchester, and was educated with his twin brother James (later the Reverend James Chadwick of Trinity Church, Bolton) at Streteford School. In 1823 Sam and James went to live with their uncle, John Taylor, a popular Bolton general practitioner, called affectionately "the Sweet Green Doctor." Impressed and enthralled by Uncle John's work, Sam Chadwick began his medical studies at the University of London in 1828, becoming a licentiate of the Society of Apothecaries and member of the Royal College of Surgeons.

Three years on he returned to Lancashire and set up practice in Wigan. Here he married an attractive young lady, Ann Hall, daughter of a wealthy wine merchant and a determined and affectionate wife who would support Sam Chadwick in all his future medical and philanthropic ventures. In 1837 the couple moved to Bolton where Dr Chadwick succeeded his uncle as the local practice. He soon became convinced that his medical and surgical skills needed considerable enhancement. In a personal programme that made modern postgraduate education look limited he went to Dublin, where he spent two winters and qualified LRCS, and then went to Scotland in 1845, where he took the LRCS of Edinburgh. He then studied and wrote a thesis on catarrhal epidemics and was awarded MD at Edinburgh.

He returned to settle down in practice in Bolton, living in an impressive house called "The Heights," and established a series of dispensaries for specialised work in addition to his own general practice. There was an eye clinic, sited in a place called Squire Alley, which is still extant, and an ear, nose, and throat clinic. Still not satisfied with his contribution to local medicine, he became an honorary surgeon at the Bolton Infirmary. The conditions and amenities of that infirmary were a constant source of dismay to him, so he determined to use some of his growing wealth—for the rich and famous travelled far to receive

his surgical skills—in establishing a new, modern Bolton Infirmary. He was not to live long enough to see his gift of £5000 turned into the Chadwick ear, nose, and throat ward of the new Royal Infirmary, a ward still active in 1983.

The breadth of his skill and surgical dexterity comes over well in the wide range of clinical papers that he contributed to

medical journals of the day. For example, in the *Lancet* of 1851 he reported the successful outcome of his surgery in a severe wound of the face and scalp in a woodman's 13 year old son, inflicted by a circular saw, lacerating muscles and several branches of the external carotid artery. The initial debridement and wound apposition seemed to be successful, but on the fourth day after the injury Dr Chadwick was called to the boy's home and diagnosed secondary haemorrhage. He operated in the bleak and awkward circumstances of a Victorian slum and had to ligate the common carotid artery. As he wrote in the *Lancet* of the ultimate outcome: "an unassuming case exists on the side of the neck and face but he had no cerebral disturbance after the operation; indeed, not one unfavourable symptom was manifest." Other articles in the *Lancet* included

Manchester

IVOR FELSTEIN, MA, author and journalist

Bolton

NASIM NAQVI, FRACS, consultant anaesthetist

Correspondence to: Dr Felstein, 14 Rochford Ave, Whitefield, Manchester M25 7PS.

At the end of the study there were still 17 patients whose asthma caused severe disability, and there was a discrepancy between the interviewer's assessment of severity and that of the general practitioner who graded the asthma of 14 as "mild" or "moderate." Thus it is likely that they received suboptimal treatment. The commonest reason for failure to control asthma effectively is improper use of the available drugs.¹¹

The results of a recent study of the management of 90 patients who had died from asthma concluded that in half the cases the asthma was not satisfactorily controlled and milder patients were not adequately supervised or educated in the management of their disease.¹² Good understanding between doctor and patient is clearly important, but it may be inhibited by the structure of consultations. If this is so does the style and length of consultations in general practice lead to failure of communication, inaccurate assessment, and inappropriate treatment for patients with chronic conditions?

The answer is almost certainly yes, but the consultation may be made more productive by using simple "tools" to supplement the work of the doctors. More use of peak flow meters and hand-held spirometers would be made of booklets and hand-outs.

Asthma diaries might be tried and a Mini-wright Peak Flow Meter could be loaned to severely affected asthmatic patients. But there is no way a substitute for good communication between the doctor and patient in the consultation.

The small degree of improvement in patient satisfaction and knowledge is disappointing because the management plan had such special emphasis on education and self care as well as appropriate drug treatment. To measure the effects of this, criteria of asthma severity were devised, and 92 patients of this criteria

Conclusions

To improve the care of their patients with asthma a group of eight general practitioners introduced a new plan of management that emphasised education and self care as well as appropriate drug treatment. To measure the effects of this, criteria of asthma severity were devised, and 92 patients of this criteria

Diary of Urban Marks: 1880-1948

One Saturday night a woman called Eliza Ann Keast was brought into the casualty department. She was quite dead and her throat showed signs of finger marks. Francis, the constable who brought her in, said that she had been strangled on the Strand by a man called Mitchell, who had been arrested. The inquest was held on Monday morning. On Sunday morning I went into the mortuary and had a good look at the corpse. There were so many nail marks and finger marks that I decided to get a photograph taken. Opposite the hospital was a photographer called Smith. I persuaded him, much against his will, to come over. I propped Eliza up in the best position to show her throat and Smith clicked the camera and almost clicked himself. He was very relieved when the photographs had been taken. At the inquest the photographs were shown and I was complimented by the coroner, Viner Leader. The press was enthusiastic about them and I became famous overnight. The man, Mitchell, was of course committed for trial to the magistrates first and from there to the assizes, where he was tried before Mr Justice Jelf.

viewed before and after the study. There was an overall reduction in the severity of asthma, particularly in children, but the reasons for this are speculative. At the end of the study 17 patients were still severely affected by asthma, 14 of whom had been considered by their general practitioner to have only "mild" or "moderate" disease. This suggests a failure in assessment leading to inadequate treatment. There was a disappointing lack of change in the patients' attitudes and knowledge about asthma during the year. We suggest ways of overcoming these problems.

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had been very rare. I insisted that this time Elsworth should accompany me. He agreed, and after the necessary order had been obtained from the Home Office Elsworth and myself in company with many police officers hired ourselves in cabs at daybreak to the scene of operations. The police kept people from watching the proceedings since the Cammells Works overlooked the graveyard. The grave was identified and the digging operations commenced. The coffin was reached floating in water. With great difficulty, it was raised out of the grave and conveyed to a small room at the back of the chapel. Elsworth and I went away from the grave toward the side. He pried open the coffin without difficulty. The door of the room was open while the police kept guard outside. The effluvia was horrible. It took me all my time to prevent myself being sick. Elsworth was smoking a strong cigar and advised me to have one. If I had done so I should have been prostrate. Then he advised me to have a drink of brandy from a flask which he had had the forethought to bring with him. In the meantime we could hear the officers outside retching, which did not tend to make me feel better. I had a look at the remains of Eliza but they were indescribable. Beyond saying that one could tell that it had been human flesh at some time or other I cannot go further. No money was found. I was wearing a cashmere suit and the small permanent dent in the necktie was still there. The body still remained. I finally gave it away. At the trial Mitchell was sentenced on the ground of manslaughter to six months' imprisonment. On the day of his release he was arrested again for being drunk and sentenced to a further period of detention.

Owing to the inquest, three police court proceedings, and the assize fees together with those from the assizes, I collected quite a lot of money and with it bought May an engagement ring, to which I referred ever afterwards as "Blood money."

"It is history" in 1850, "Gunshot wounds of the cervical region" in 1852, and "Umbilical hernia" in 1854. National acknowledgment of his surgical expertise came in 1858 when he was made a fellow of the Royal College of Surgeons in England.

Public health

Not content with surgery and medicine in therapeutic form, he turned his attention to public health and preventive medicine. Firstly, he set about tackling health education. He gave a large amount of money to establish a mechanics institute, then offered a series of lectures to members and the public on the importance to health of water and air. Using the visual presentation of simple but scientific experiments and explanatory comment he gave, for example, a dissertation on 9 February 1859 on "Water, its distribution, physical and chemical properties, its impurities and its mode of detecting them." Another such lecture was "Atmospheric air, some of its properties," and a third was "In relation to animal and vegetable physiology."

Next in his own campaign for public health he established with personal funds a charitable trust of £22,000 to erect "model dwellings for workpeople now condemned to living in cellars." These clean, spacious, and low rental houses were built in Peabody Street in Bolton (Peabody was the architect who designed the premises) and are still there. Dr Chadwick had no doubt that bad housing encouraged "contagious and unsanitary diseases" in the working but poorer citizens. His idea of slum clearance was 90 years ahead of its time.

The third prong of his public health attack on the unsatisfactory environment of his adopted town was to seek election to the Bolton Council where he could not only speak his mind as a doctor but make official representations as a councillor. When possible he spoke up for improvements and better facilities for his fellow Boltonians. In one address at the town hall he declared, "If you were to tell persons to wash up after dinner and then insist they put that water aside for making tea you would see the absurdity of this. Where then is the propriety of offering citizens already used water?"

On another occasion, ridiculing his wealthy fellow councillors who decamped to seaside towns whenever an epidemic broke out in Bolton or nearby Manchester, he assured them that, "I can cross the Irish Sea with less difficulty than I can ride round [the sewage and garbage] to the shores of the town. He established the Chadwick Orphanage in Bolton, which housed as many as 80 girls at a time, and went on doing so until the coming of the welfare state in 1948. He then turned his attention to Bolton's workhouse, known as Fishpool, and donated money to improve the amenities, among other things providing a large organ for musical entertainment to cheer up the inmates. A local newspaper reported that "the joy of the poor inmates knew no bounds."

Orphans and the workhouse

Prosperous, famous, and happily married, Sam Chadwick shared one overwhelming sorrow in his life with the woman he so loved. Both his son and daughter died in infancy and there could be no more children. This undoubtedly encouraged him to turn his philanthropic attention to the needs of the town. He established the Chadwick Orphanage in Bolton, which housed as many as 80 girls at a time, and went on doing so until the coming of the welfare state in 1948. He then turned his attention to Bolton's workhouse, known as Fishpool, and donated money to improve the amenities, among other things providing a large organ for musical entertainment to cheer up the inmates. A local newspaper reported that "the joy of the poor inmates knew no bounds."

Education was still on his mind when he gave another large sum of money to be used to establish a free public museum, to be built in Bolton's Queen's Park. This was the foundation for the Bolton Museum, which has since been moved to a new museum resided in the city centre.

While Sam Chadwick devoted his energies to the health and welfare of others, his own health steadily deteriorated. He had had rheumatic fever as a child and there was residual valvular

dysfunction. On top of the cardiac problem, he developed bronchitis, undoubtedly related to the pollution of the environment against which he so long campaigned. At the age of 54, he retired prematurely and resided in the fresh sea air of Southport in Lancashire. His final beneficent act before retiring was to create a fund—to which he gave a large contribution—to help exiles and refugees from Europe. His retirement in 1863 was marked with a gift to him of a life size painting of him in oils. The cost was defrayed by the spontaneous contributions of nearly 8000 citizens. Ten years later, shortly before he died, Bolton gave him the permanent niche in their hearts by erecting the Chadwick statue that still stands today.

Sam Chadwick died at Peel House in Southport on 3 May 1876. His body was brought back to his favourite town of Bolton, and he was buried in the parish churchyard. In just over four decades of his adult life he had given gifts, contributions, and donations for the betterment of Bolton citizens to the modern equivalent of well over £1m. This was apart from his personal, medical, and surgical triumphs was improving individual and collective health. No wonder the *BMJ* of 27 May 1876 published his obituary under the title "A Medical Benefactor."

Diary of Urban Marks: 1880-1948

During the year Dr Nelson Joost built a cottage at the top of Caswell Hill overlooking the bay. He was very proud of it and invited all and sundry to it. Going down on the old Mumbles train with him to the cottage one afternoon he asked me what I intended to do when my year of office came to an end. I told him that I had no object in view, except to be a house physician somewhere and then to take a trip round the world before I settled down. He then asked me if I would care to come as an assistant to him with a view of partnership. He said that he was getting on in years and wanted to play golf more. He was in no hurry and after some discussion, I promised to see him immediately on my return from my voyage.

During December I applied at Derby, Gloucester, and Worcester for the position of house physician. I was on the short list at each place but was finally selected by the Worcester committee. I took my duties there on the first day of the year, going there direct from Swansea. There were only two residents there, myself and McFerridge the house surgeon. I was informed by the junior doctor that I should have to give anaesthetics for the surgeons because the honorary anaesthetist never came near the place. The surgeons in order were Bates the senior, Gostling and Pollard, and I was told that none of them would allow anything but ether to be given because some deaths had occurred under chloroform lately and as all of them were general practitioners in the town, these unfortunate occurrences reflected badly on them. They came in every morning at 9 am and looked round the wards. Each of them operated in turn and each assisted at the Mac if that was the usual procedure of Bates and myself. 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