PRACTICE OBSERVED

Practice Research

General practitioners' views on asthma in childhood

B E MARKS, V F HILLIER

Effective control of asthma in childhood largely depends on the quality of diagnosis and treatment in general practice, where there are unique opportunities for early recognition, appropriate treatment, and education of parents and where an unknown but certainly high proportion of cases is managed. Evidence of deficits in general practitioners' knowledge about either diagnosis or treatment would cause anxiety in a disorder with a disturbing mortality, high morbidity, and effective treatment.

The results of a study of children who had been referred to outpatient departments in Newcastle upon Tyne and London showed both underdiagnosis and undertreatment by general practitioners, and it was suggested that among the reasons were preoccupation with infection as a cause of respiratory illness and, possibly more important, reluctance to use the term asthma. More recently, the results of a semistructured patient management problem about an evening home visit to an 8 year old boy with a fairly severe attack of asthma which was completed by over 300 general practitioners showed that of the 209 who chose initial treatment at home only 46 were given steroids by any route. Sixteen and 14 doctors regarded cromoglycate and antibiotics respectively as appropriate treatment for the acute attack.

Appreciable deficits in treatment were shown in a study of the use of drugs in the treatment of a representative sample of wheezy 9 year old children in the London Borough of Croydon.¹ One third of the children who had disturbed nights and restricted activity had not received treatment for asthma during the previous month. Only 14% had used cromoglycate or

inhaled steroids to prevent their asthma. The authors commented that use of the word asthma by the general practitioner is a major factor in determining anti-asthmatic treatment.

The results of a recent survey in Tyneside of 170 children aged 7 with a history of wheezing showed that the parents of only 21 had been informed that the problem was due to asthma and that these parents were almost invariably relieved to be told the diagnosis and to be given guidance about future management.² The authors concluded that the reluctance of many practitioners to label children as asthmatic was without foundation. Willingness to make the diagnosis made it much more likely that treatment with bronchodilators would be prescribed.

Thus it is interesting to note the differences recently reported between the opinions of paediatricians and general physicians on the management of children with asthma and on the nature of the advice given to parents and children.³ There was much difference of opinion between the two groups of specialists on over half the topics in a postal questionnaire, and the authors are concerned about the different advice that specialists may give to general practitioners and to patients.

In this study we investigated the difference between the information that general practitioners had about asthma in childhood and that of several experts by comparing their views on a series of statements about its prevalence, diagnosis, and treatment.

Methods

A series of 10 statements about several aspects of asthma in childhood was sent by post to 107 general practitioners who had consecutively referred patients to a paediatric outpatient department that mainly treated asthmatic children. This group of doctors was chosen in the belief that they would give a high response rate to the inquiry and that as referrers of children with respiratory problems their views would be of particular interest. They were asked to indicate their opinions about each statement on a seven point scale, ranging from strong agreement to strong disagreement. In addition,

2, and 3 showed some agreement and ratings 5, 6, and 7 some disagreement with each proposition. For example, the consultants in their responses to statement 3 agreed with the proposition (ratings 1, 2, and 3), whereas the 26 general practitioners who answered in the 5-7 range were categorised as expressing disagreement with it and were therefore in disagreement with the consultants. Similarly, in statement 1 the 20 doctors who answered in the range 1-3 were counted as disagreeing with the consultants.

The personal and practice characteristics of respondents were compared with their disagreements with the opinions of the consultants. Age, time spent in general practice, place of qualification, and whether they practised single handed, in partnership, or in a health centre or other premises did not influence the number of disagreements. Two groups of general practitioners, undergraduate teachers and trainers, had a significantly smaller number of disagreements with the consultants than non-teachers and non-trainers respectively (Mann-Whitney U test).

The median number of disagreements with the views of the consultants for respondents who taught medical students was one, whereas general practitioners who were not teachers had a significantly higher ($p < 0.05$) median of two. The means were 1.83 and 2.07 respectively. Similarly, the median for trainers was one (mean 1.85), while for those who were not trainers it was three (mean 2.85). These differences are highly significant ($p < 0.01$). Table IV gives the frequency of disagreement with the consultants for all respondents, and for undergraduate teachers and "non-teachers" and trainers and "non-trainers" respectively.

TABLE IV—Comparison of disagreement between general practitioner respondents and consultants

No of disagreements	Frequency of disagreement				
	All respondents	Teachers	Non-teachers	Trainers	Non-trainers
0	7	3	4	6	4
1	11	7	11	6	11
2	18	13	15	4	14
3	11	7	6	4	10
4	5	6	0	0	5
5	6	0	6	0	6
6	1	1	0	1	0
7	1	1	0	1	0
Total	77	18	58	27	49

Discussion

The results of this study support the findings of earlier surveys that a proportion of general practitioners has an inadequate understanding of the problems of children with asthma. Caution, however, should be exercised in interpreting the results because the general practitioners who were asked to take part in the study had all referred children to the outpatient clinic, while the views of doctors who had not made referrals remain unknown.

The variation in the respondents' opinions about early morning cough and exercise induced wheezing, symptoms about whose importance the consultants were unanimous, suggests that there is insufficient knowledge about the more undramatic and less stereotyped ways in which asthma frequently presents in childhood. Excessive emphasis on infection as the principal cause of recurrent respiratory illness in childhood is shown by the views of a sizable minority of respondents on the statements about the prevalence of recurrent bronchitis in young children, the frequency of chest infections in asthmatic children, the treatment of asthma with antibiotics, and the aetiology of early morning cough, and it seems likely that this attitude is an important factor in the failure to recognise asthma in childhood and treat it adequately.

The fact that its high prevalence was not acknowledged by the considerable minority of respondents who believed that recurrent bronchitis was common in young children though

asthma is not underlines the difficulties already discussed about early diagnosis. Other authors have reported that the reluctance of general practitioners to use the term asthma reduces the likelihood of appropriate treatment being given, a view supported by the opinions of many respondents about treatment with antibiotics, cromoglycate, and bronchodilators. There may be many explanations for this, among which is the operation of a mental mechanism founded on a lack of understanding of the effectiveness of appropriate treatment and of the need of parents to be given a rational explanation for their children's recurrent respiratory symptoms.

The results of this study suggest that a proportion of general practitioners lack awareness of the less classic ways in which asthma may present in childhood, are unfamiliar with current ideas about both prophylactic and symptomatic treatment, and are preoccupied with infection as the principal cause of recurrent respiratory problems in childhood. That teachers and trainers differed least in their views from the consultants suggests that the difficulties concerning the management of childhood asthma in general practice may perhaps be resolved in a relatively short time as students are exposed to the influence of teaching practices and the effects of vocational training are felt.

Meanwhile, children with asthma experience unnecessary ill health with restricted activity, disturbed nights, time off school, inappropriate medication, and repeated hospital admissions, much of which is preventable. Every opportunity should be taken by educators concerned with training for general practice and with continuing education to communicate to their audiences the essential information about asthma in childhood, without which effective treatment is not possible.

Conclusions

Seventy seven general practitioners and seven consultants with a special interest in respiratory paediatrics rated their attitudes to statements about asthma in childhood on a seven point scale. Comparison of the ratings of the two groups showed statistically significant differences in nearly all instances. There seemed to be no correlation between the ages and practice characteristics of the general practitioner respondents and their views, but general practitioners who were undergraduate teachers or trainers showed the least disagreement with the consultants. The findings suggest that a proportion of general practitioners is not aware of the less classic ways in which childhood asthma may present and is unfamiliar with current thought about treatment.

We thank the doctors who took part in the study and Professor David Metcalf for advice and support.

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doctors received a questionnaire inquiring about their age, place of qualification, how long they had been in general practice, characteristics of the practice, and whether they taught undergraduates in their practices or were trainers.

Seven consultants with a special interest in childhood asthma were asked to express their views about the 10 statements using the same rating scales, and their opinions as experts were used as a standard with which the views of the general practitioners could be compared.

TABLE I—Age of general practitioner respondents

	Age (years)				
	30-39	40-49	50-59	≥60	
England 1977 (%)	7	25	27	26	15
Respondents (%)	5.3	19.7	25	28.9	20.8

TABLE II—Practice characteristics and place of qualification of general practitioner respondents

Single handed (%)	In partnership (%)	Health centre (%)	Premises		Other (converted) (%)	Britain (%)	Overseas (%)
			Purpose built (%)	Residential (%)			
16	84	33	13	87	54	81	17
19	81	18	21	79	61	72	28

TABLE III—Opinions of respondents and consultants

	Strongly agree										Mean	Median
	1	2	3	4	5	6	7	Strongly disagree				
Respondents n = 76	27	12	5	13	5	5	2	4	4526	5		
Consultants n = 7	0	0	0	1	0	2	4	0	6296	7		
Statement 1: Recurrent bronchitis is a highly prevalent condition in young children												
Respondents n = 77	24	22	9	5	3	2	0	0	2870	2		
Consultants n = 7	0	0	0	0	0	0	0	0	1571	7		
Statement 2: Antibiotics are a logical treatment for attacks of asthma in childhood												
Respondents n = 77	6	18	12	15	13	8	5	0	3689	4		
Consultants n = 7	0	1	0	0	0	0	0	0	1571	7		
Statement 3: Asthma is a common condition in children under the age of 4												
Respondents n = 77	15	13	11	7	8	13	9	0	3740	3		
Consultants n = 7	0	1	0	0	0	0	0	0	5296	6		
Statement 4: Inhaled steroids should be used with caution in children with asthma because of the possibility of side effects												
Respondents n = 76	0	11	10	5	19	11	0	0	4261	4		
Consultants n = 7	0	0	0	0	1	1	5	0	6571	7		
Statement 5: Children who frequently wake in the early morning with a chesty cough usually have a persistent upper respiratory tract infection												
Respondents n = 77	0	0	0	0	0	0	0	0	2623	2		
Consultants n = 7	0	0	0	0	0	0	0	0	1571	7		
Statement 6: It is possible for many 4 year olds to use an inhaler effectively												
Respondents n = 77	0	0	0	0	0	0	0	0	5006	6		
Consultants n = 7	0	0	0	0	0	0	0	0	1571	7		
Statement 7: Coughing and wheezing after physical exertion is not of great diagnostic importance												
Respondents n = 77	0	20	9	14	8	9	8	0	3662	4		
Consultants n = 7	0	0	0	0	0	0	0	0	1967	1		
Statement 8: Deformity of the chest wall is more often the consequence of inadequately treated asthma than poor posture												
Respondents n = 77	0	0	0	0	0	0	0	0	2556	2		
Consultants n = 7	0	0	0	0	0	0	0	0	1143	1		
Statement 9: Episodes of wheezing in children who are not systemically ill are best first treated with bronchodilators alone												
Respondents n = 77	0	0	0	0	0	0	0	0	3675	5		
Consultants n = 7	0	0	0	0	0	0	0	0	5714	6		
Statement 10: Asthmatic children get a lot of chest infections												

Results

RESPONDENTS

Seventy seven replies were received, a response rate of 71%. Non-responders were not followed up. The ages of the respondents were compared with those of a 1977 national sample of general practitioners in England (table I). Respondents were slightly older than the doctors in the 1977 national sample. Thirteen per cent had been in practice for less than five years, 28% for five to 14 years, 26% for 15 to 24 years, and 33% for over 25 years. The practice

with the Mann-Whitney U test. For statements 1 and 5 there were 76 respondents and not 77 (one reply was omitted in each), and one doctor failed to answer the question about teaching and training.

Only in statement 4, which was concerned with the adverse effects of treatment with inhaled steroids, did the difference between the ratings of the two groups fail to achieve significance. For the remaining nine statements the differences were highly significant ($p < 0.01$) in two (statements 1, 2, 3, 5, 7, 9, 10) and significant ($p < 0.05$) in seven (statements 6 and 8).

Except for statement 4 it was possible to identify the doctors who disagreed with the consultants on each statement separately. Ratings 1,

First Five Years in Practice: the 1920s

After the first world war

S WAND

There have been so many radical changes in medical training, organisation, economics, and practice since the first world war that for a proper appreciation of conditions then existing it is necessary to go into some detail. Most hospitals, including the teaching hospitals, were voluntary—that is, were dependent on voluntary public subscription; others were under the aegis of boards of guardians. In voluntary hospitals consultants were unpaid or received a small honorarium. For income they depended on private practice carried on outside the hospital. Resident medical staff received a salary, juniors in a teaching hospital received about £50 a year plus accommodation, food, and laundry. In non-teaching hospitals salaries were higher. Board of guardians hospitals, in which the staff were full time and paid, were developments of the workhouse infirmaries. While the infirmaries continued to be used for the chronic sick poor, the hospitals were advancing rapidly in the quality of clinical care.

General practice was usually carried on at the doctor's residence. Many doctors also had branch surgeries. Income in industrial areas was derived in part from capitation fees for National Health Insurance patients and in part from private practice. National Health Insurance covered general practitioner care including medicines (obtained from a chemist on prescription) for the lowest paid workers only. Their dependants as well as consultant services were excluded. There was no provision for pension for the doctor.

To help ease the financial pressure for medical care at the time of illness arrangements for the collection of weekly payments were made in some areas. These "clubs" were organised by the doctors or an outside agency, particularly in the colliery areas, which paid the doctor a capitation fee, the amount of which often led to dispute. For those too poor to pay there was a Poor Law medical service—understandably not very popular. For private patients doctors did their own dispensing—usually mixtures made from pre-prepared stock bottles. Successful practices employed dispensers. Others could not afford to do so. At the doctor's home receptionist duties were usually carried out by the doctor's wife or the maid and at the branch surgery by the caretaker.

In a practice in an industrial area a full time receptionist or practice nurse was exceptional. Where the doctor or his wife did not conduct the business side of the practice, a clerical assistant was employed. This was a part of general practice for which the newcomer was usually totally unprepared. Apart from a district nursing service, supporting services were virtually non-existent. The only social worker was the hospital almoner. There were no health visitors, no district nursing attachment to practices, no

publicly organised ambulance service, no meals on wheels or laundry service, and no health centres. Child welfare clinics were soon to appear. At first there was little co-operation between them and the family doctor.

Apart from some local variations, such as small general or cottage hospitals with a general practitioner staff, this is general terms was the setting in which the incoming general practitioner found himself at that time.

Setting up in practice

Entry into general practice was by purchase into an existing practice, sometimes after a preliminary assistantship, or by putting up a plate.¹ The doctor who put up a plate in an established area already fully doctored was understandably not always well received by his colleagues and the survival rate was low. After the first world war, however, there were some new developments to compensate for the absence of building during the war and for slum clearance. These provided many recognised opportunities.

Purchase and sale of the goodwill of practices continued until 1948 when, under the National Health Service Act, provision was made for the ultimate payment of an agreed sum to compensate for the abolition of the right to sell a National Health Service practice. Depending on the type of practice and the likelihood of maintaining the income, the purchase price was around one and a half times the average gross earnings.

The incoming doctor had to buy or rent premises, and furnish and equip them, so that quite a lot of medical students were Money was not easy to save on the salaries paid and there could be problems in obtaining a loan. The doctor going into single handed practice (and most practices were then single handed) who could find no collateral or guarantee was not regarded as a good risk, and there was no General Practice Finance Corporation. I emphasise the financial side because remuneration of the average general practitioner was low and was the cause of much anxiety (as well as a spur) in the years during which the doctor was becoming established in practice.

I started medicine in 1915, having so many of my contemporaries, then classics and virtually no science at school. The first MB (the full course lasted under five years) was given nine months to reach the necessary standard in chemistry, biochemistry, physics, biology, and zoology. Having reached military age during my second MB course, I joined the army (in a non-medical capacity) and with other medical students was compulsorily repatriated from France in mid-1918 because of the casualties among doctors. The shortage was such that fourth year students were engaged in fully qualified work as hospital residents, when visiting a friend in such a post I was pressed into giving an anaesthetic (chloroform and ether) to a case of acute intestinal obstruction. I had never seen an anaesthetic given and knew nothing of anaesthesia. The patient made a good recovery. In due course as a student I was able to take similar

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short term posts. The experience was valuable for me as a postgraduate year 5 and no training requirements. Those who had qualified were regarded as competent to enter general practice.

I had decided to go into general practice and financial and domestic circumstances were such that there was no point in delaying getting myself established. It was not easy for an impecunious young man to find a practice. I did several locums in hospital and general practice, and in due course I found a share in a small practice in an inner city industrial area, from which the vendor intended to retire after a short time, at a price that I could afford with the help of a bank loan guaranteed by a relative—a guarantee that I was pleased to be able to extinguish after a short time.

These locums gave me an insight into general practice. I noticed the absence of equipment, even of a sphygmomanometer. The surgery carried out by general practitioners on the staff of the small town hospitals in which I worked varied from very good to appalling. On one occasion, after I had assisted at a hysterectomy, the surgeon confided to me that it was the first he had done and had read it up the night before.

The salient features of the transition from hospital to general practice were isolation and full personal responsibility. There were no senior colleagues on hand for the spot consultation, no help from an experienced ward sister, no skilled nursing staff to carry out instruction, no physiotherapy save on a paying basis, and no immediate access to a hospital bed for observation in a doubtful case.

Isolation, however, was not complete. Referral to a consultant at an outpatient department required only a letter to be taken by the patient—no appointment was necessary. In acute cases requiring admission this could usually be arranged by telephone. If this failed a letter sent by hand to the Relieving Officer, day or night, ensured a bed and transport if necessary, at a board of guardians hospital. This applied also to psychiatric and geriatric cases. A domiciliary visit by a consultant entailed the payment of a fee by the patient. This was sometimes waived if the patient could not afford it. Laboratory investigations were readily available for tuberculosis, diphtheria, and venereal disease. There was no direct access for any other investigation.

The modern precision drugs were still a long way off. Insulin had just been isolated; the first of the antibiotics was still over 20 years away. The modern cardiovascular drugs, anisodiazines, antidepressants, endocrines, steroids, and many others with specific action were far in the future. Immunisation for diphtheria, whooping cough, and polio was yet to come. Diseases not often seen today were common—acute rheumatism and chorea seriously affecting the heart, typical acute lobar pneumonia (a frightening disease), erysipelas, mastoiditis, and other serious complications of otitis media. Pulmonary tuberculosis was widespread. Diphtheria, scarlet fever, whooping cough, and measles all had high death rates. A septic finger often led to a disability that could render the patient virtually unemployable.

This was the period of the depression of the 1920s with the General Strike in 1926. There was much unemployment and poverty. I saw children going to school in winter in threadbare clothes crying with the cold. "Dole" payments were meagre. Housing conditions in many working class areas were appalling—no bathroom, outdoor sanitation common to two or more houses, leaking roofs, damp walls, and no central heating. Many had landlords who did not repair. The deleterious effect of all this on health and the doctor's income needs no emphasis.

Many home visits

The practice grew and I soon found that there was not time for the unhurried case history and examination as in hospital practice. There was a rapid succession of different cases with the expectation by the patient of an immediate, firm, and correct diagnosis. The only surgical procedures I undertook were

simple ones such as suturing of wounds, opening of abscesses, removal of sebaceous cysts, and circumcisions.

The visiting list became heavy. Requests for visits were scattered throughout the day and night, most on acute febrile conditions about which relatives were, without good cause, worried. Acute illnesses were protracted and frequent recurrences were necessary. In winter 30 visits or more a day in addition to attendance at surgery was not unusual, and in epidemics (there were two serious influenza epidemics in the 1920s) many more.

Midwifery requires a special mention. Nearly all confinements were carried out in the home. Some were "booked" with qualified midwives only, and often the doctor was faced with an emergency when sent for by the midwife in a case he had not seen before. Others were booked with the doctor, who might find himself with the help of only an unqualified maternity nurse.

The need for antenatal care was not fully understood by the public and even in "booked" confinements many patients failed to attend for antenatal examination and, indeed, the suggestion was sometimes resented, so that even at a booked confinement the doctor might not have seen the patient for some time. I often found that I had to give an anaesthetic and at the same time carry out any necessary manoeuvre—a traumatic experience which fortunately later became unnecessary. Midwifery, however, was one of the most satisfying parts of a general practitioner's work and many a doctor's reputation was built on successful midwifery.

At this time there was an undercurrent of fear about going into hospital for an operation. Surgery was not universally successful. There was also a feeling of disgrace about allowing a relative to go into the infirmary. Relatives and neighbours did all they could to care for old people in their homes. The general practitioner was trusted and relied on even if all he could offer was hope and comfort. He had to be caring. The chosen doctor himself was expected to be available at all times. This was the doctor-patient relationship, but it meant round the clock work of a fee by the patient. This was sometimes waived if the patient could not afford it. Laboratory investigations were readily available for tuberculosis, diphtheria, and venereal disease. There was no direct access for any other investigation.

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ONE HUNDRED YEARS AGO It is proposed, in consequence of the number of deaths which are occasioned by colds caught at funerals, that skullcaps and gunes and Schevenings wind-screens at the grave shall be a regular paraphernalia of funerals as the pall, the "weepers," and the hearse-horse. The suggestion, says the *York Herald*, is a practical and generous one. It is in line with the recently adopted provision of India-rubber suits for baptism by total immersion, and bears testimony that we live in a progressive age. A better system, however, is that established in Ulster, in Omagh county. The principal cemetery there is provided with two chapels—one of stone, where funeral services are held in the summer, the other of iron and glass, where they are held all the rest of the year. Into this "conservatory chapel," full of tropical verdure, the funeral train passes through a covered carriage-way, and the services are held in light and warmth, among trailing vines and blooming shrubs. At their conclusion, the corpse is surrendered to keepers, who, after the mourners have departed, remove it to a cold vault to await interment in a grave. (*British Medical Journal* 1883; 974.)

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constantly struggled to produce a physical diagnosis for each of the many incidents. Later, after being converted to a "Baini" approach, I tried to understand the dynamics of the multiple interactions and even to "interpret" symptoms to the combats. If ever there was a method designed to unite a family against the doctor this was it. Other members of the family would at once side with the overt patient who would scold me with my obvious thesaurus.

I make no claim that my tentative hypotheses were right, but by the time they had been retold two or three times the doctor was undoubtedly an arch villain and the patient untreated, undiagnosed, and certainly not at all happy with the situation. The lesson has stayed with me. Don't produce psychological theories to explain "obviously" psychosomatic symptoms unless the patient first shows a willingness to listen and, secondly, is sufficiently in tune with the doctor to accept what always appears as an unpalatable truth. How often since I have stayed tactfully silent on the functioning of the psyche when the blood count, chest x-ray examination, barium meal, or whatever, has come back normal. "What is it then doctor?" is not an invitation to

discuss marital disharmony, child mismanagement, parental tantrums, incompetence at work, or failure to get promotion. The lead in has to be slow and patient. Meanwhile the symptoms have to be managed symptomatically for as long as necessary.

In those days Mist Mag. Trisulicase or Lintecus Gee were relatively inexpensive and safe. Now we are faced with demands for a better antibiotic, "penicillin does not suit me"—or casual repeat prescriptions of cimetidine "just in case." "I just bend like the willow" a colleague told me some years ago when the pressures of a large list of patients were wearing him down. I can't, and I suppose this family taught me that to stand and challenge may be equally useless. So now I try to duck and weave my way through the fascinating problems of general practice, occasionally scoring a try but still often falling flat on my face, being tripped up from behind, or being knocked flat by a problem that must have been obvious from the sidelines. I really must try to be more patient, tolerant, and understanding in future. As the advertising men say "you can't win them all" but there is a need to keep trying.

Papers That Have Changed My Practice

Respiratory disease and hypertension

JULIAN TUDOR HART

Change at our health centre occurs in two stages, talking about it and doing it. These are separated by an obligatory phase of verification: measuring what our team is doing by some sort of random sampling. Almost always this shows that talking is not followed by more than taken doing, until conscience is confronted with incontrovertible evidence of failure to carry out decisions.

Extension of conscience is where it begins, and this usually comes from scientific papers. I imagine that most regular readers of medical journals are secretly relieved to find only two or three papers at most that are comprehensible; if a journal ever appears that it is compulsive reading from beginning to end I hope that I won't meet it until I am safely retired. Really important papers that force us to revise practice are fortunately rare. Rarer still are those so fundamental that application of their conclusions in practice becomes the work of a lifetime, a process too complex for easy division into talk, verification, and action. The first paper I remember doing that to me was an editorial in the *Journal of the American Medical Association* in 1953 reviewing the evidence of blood dyscrasias after the use of chloramphenicol. When I got to read it on three years later I was a general practitioner in Notting Hill Gate, London. In the same week I was called to see a boy of 9 who had come home from a residential private school after three months of persistent coughing after an attack of whooping cough. Throughout the time he had been treated continuously with 2 g chloramphenicol a day. Later that week I was visited by a sales representative who advised me that he was the antibiotic of choice for all common childhood infections.

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That paper permanently changed my practice without any painful process of reorganisation. From that time I decided not to see sales representatives and asked the Association of British Pharmaceutical Industry to delete my name from all future promotional mailings (which they did, and still do, with a good grace) and henceforth to get my news from the journals. Of course, in those days all the journals were serious, because we paid for them: the medical comics had not been invented.

On balance, this policy has paid off handsomely. I could not believe that a drug that didn't kill you if you took 500 capsules did it could have any psychotropic action, so my patients were deprived of the benefits of benzodiazepines for about five years. The other result was positive: I never prescribed thalidomide because my first news from the journals, of course, was about peripheral neuropathy. I never prescribed praloxone because, having started very early with propranolol (which the journals quickly recognised as a genuine and useful innovation), there seemed no urgent reason to adopt new drugs. I didn't know. I never prescribed bexonaproxen because it seemed clear from the editorials that nothing fundamentally new had happened since indomethacin. I therefore remain in a high respect an unrepentant conservative and am still astonished at the thirst of my colleagues for therapeutic novelty.

Peak flow rates

The next big journalistic event I can recall was Ian Gregg's paper on the distribution of peak expiratory flow rates in a population of non-smokers.¹ In those days a Wright peak flow meter was a serious investment: about £50 of real money. I had just started work in Glyncorwg and had only 500 patients. Archie Cochrane, horrified by my news from the journals, and its neighbourhood, generously offered to replace the wooden

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A Difficult Case

Contributions to this series are welcome for consideration

Pandora's box

K G DICKINSON

Some names, some road numbers, some voices become imprinted in one's mind over the years. The cases are not just difficult but impossible to deal with adequately. It was such a family that forced me to try to understand how people interact and why. I never really discovered the answer and so moved practice. The family was already well established on the list when I took over in 1958. Great grand-grandfather lived about 100 yards from the surgery and "required" a regular two weekly visit supplemented by others when her daughter visited and found that she was "not as well as could be expected."

The previous doctor "always came" on request. The daughter, aged then about 50, was also a dominant mother and a "take over" grandmother. With her lived her husband—a heavy smoker and drinker who provided me with no problems except his cirrhotic liver, developing dementia, and death from carcinoma of the bronchus. I liked him over the years, sympathised more and more with his retreat to the public house or the garden shed. He unfortunately never supported me in the family battle. He was probably right. I rarely won.

Also sharing the house at that time with the mother and father were two daughters and a granddaughter. It took me some time to work out that the granddaughter, Penelope, was the only daughter of Myrtle who lived six miles away and had given Penelope to her mother one day because she "could not" Penelope was "special." Where most children have three or four cousins during the winter Penelope had one or two a week. They were very friendly, very mildy critical. I sometimes two. If ever I failed to go the next morning there would be a fearful summons to see a feverish child. Each time the fever was definitely there. How did Penelope do it? I had not at that time heard of psychogenic fever and have little time now to know more.

Later, as Penelope progressed to primary school, the pattern changed and the calls were for abdominal pain or vomiting. Grandmother was large, friendly, and mildly critical. I provided medicine and school notes. Much chaos developed if I did not. My secretary-receptionist and housekeeper would have all about it when they shopped locally, and inevitably the local doctor on rota would call out as soon as I had a half day off to rectify my shortcomings. They always acquiesced. Who can blame them?

When Penelope was about 9 years old grandmother came to the surgery to tell me that Penelope's mother was very ill. Her own doctor could not cure. Myrtle had therefore decided to move house to be near her mother. There were certain problems I later learnt about debts, overvalued stock, mortgages, and the building society. But somehow Myrtle and her husband Bill moved nearby and registered with me. I think that it would

now be fashionable to talk of Myrtle's "irritable bowel syndrome." Twenty years ago this term had not been invented. Even now treatment is "symptomatic" and it was difficult with Myrtle as the symptoms enveloped the whole body. There were, however, two gains—a lasting friendship with a famous consultant physician who tried to do a lumbar puncture and was surprised to see Myrtle vanish from the ward, and the offer of a clinical assistantship from a consultant psychiatrist who had a consultation with her that lasted only three minutes and who ever after felt a very great sympathy for her.

Then all the symptoms settled. Myrtle had taken Penelope home. Grandma collapsed, became fearful, aggressive, and vindictive—after all I've done over the years. "Bill, a small, weak, insignificant man, took to drink. Penelope started to have abdominal pain and vomiting again. I just had a different house to visit for six months until grandma ambushed Penelope on her way home from school and took the poor dear" back again. Myrtle blamed Bill, who stormed down to grandma's house, broke a window, and was punched in the nose by grandma.

Shortly after this the carcinoma of the bronchus finally removed grandpa from the scene and at about the same time Bill left Myrtle. Fearful recriminations turned into mutual egocentric support, and Myrtle moved in with Penelope to be nurtured once more by grandma. Sudden realisation that a house would be possessed by the bailiffs sent Myrtle back home again a month later with Penelope. Grandma was now losing weight, not sleeping, and becoming breathless, and for the first time in years I stopped and looked at her. How long had she been cyanosed and oedematous? The hypertension was not at all adequately controlled, and the crepitations persisted at the lung bases. Grandma retired to bed. Penelope, now a young adolescent, moved back to nurse her. Myrtle blamed me for incompetence for telling everyone that "it was all in the mind."

The district nurse visited regularly. A certain ritual developed of two weekly visits by the doctor with others on demand when her daughter noted that she was "not as well as could be expected."

Do psychogenic crepitations exist or was my stethoscope just conditioned by 12 years of misuse?

Lessons learnt

Looking back at this family a decade later I feel a sense of regret at my failure to understand genuinely the situation at all but even more a sense of relief that I am no longer closely concerned in their fortunes. If ever I thought that doctors were all powerful then I was surely taught here that my role was that of a family doctor and not that of an inveterate aggressive, intolerant, or take short cuts invariably rebounded on me. They were far better at the game than I was. I developed a sensitivity, and so did my staff, though in different ways, to their needs.

The failings of my training as a medical student became more and more self evident in the initial contacts, when I

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shed in which I practised with a health centre of my own design, paid for from his pocket. That didn't seem the right way to do it so we settled for a flow meter, and it probably had as big an impact on practice as my new buildings would have done.

The flow meter changed qualitative decisions based on chest squeaks and apparent distress to quantitative decisions at least partly modified by objective evidence. The flow meter, now available at about £10 a throw and in both high and low reading versions, is a wonderful learning instrument. It teaches the fallibility of auscultation and, like a sphygmomanometer, permits quantitative decisions along a continuous distribution rather than a simplistic division into disease and non-disease categories. The chest falls of squeaks, nevertheless functioning not too badly at flow rates of 400 or so, and the stethoscopes without any physical signs with a peak expiratory flow rate of 105 can, with a flow meter, be ranked intelligently. In the London teaching hospitals of the early 1950s chronic bronchitis and emphysema, and the patients who had them, were rubbish. Here was an extraordinary ordinary general practitioner, who brought some dignity and science to the daily business of medicine.

There are still practices in Britain without flow meters, and plenty of general practitioners who give higher priority to stethoscopic music than to the only respiratory function test easily available in the field, where it is really needed. Outside Britain and Scandinavia few clinicians seem even to have heard of flow meters; they use either computerised multichannel spirometers or nothing at all. To know all the peak expiratory flow rates and all the smoking histories in a population is the beginning of serious work on controlling respiratory disease and personalised smoking control, we owe that first step to a general practitioner who published hard, across the board data from his whole population at risk, while the rest of us were just counting cases.

Arterial pressure

Round about the same time Pickering published his papers on the distribution of arterial pressure in the general population and began his battle with Platt² on the nature of hypertension. The idea of hypertension as a generally asymptomatic quality (a risk factor for disease) rather than a symptomatic quality (a disease itself) was entirely natural to a general practitioner, particularly to a Marxist (though that, Pickering certainly was not). The Platt Earth Society was poised to Pickering's Galileo. Pickering won hands down, but his victory was not as easily uncelebrated: perhaps its logical consequences are still too uncomfortable to too many people. How simple the world is, when all we have to do is to learn how to shoot the diseases without killing the patients. A new commodity, a new tool, or new certainties rather than communications in doubt. But we in Britain had a free health service (interesting contradictory word, "free"), and no longer needed blind faith in the goods we had been selling. We now had to distribute according to need, permitting a more realistic scepticism.

That paper changed my world. After a brief spell in full time epidemiology had proved to me that other people could do it better I looked for a geographically defined population where long term clinical epidemiology could be done easily, and the obvious subject to go for was arterial pressure. Everybody had one, lots of died of it, effective and tolerable drugs were becoming available for the first time, everywhere people who needed them weren't having them, and, to a growing extent, people who didn't need them were having them. This was the ideal tracer condition; if we could control high arterial pressure in small

whole populations we would have an effective model for the role of anticipatory primary care in the community.

From experience of these three publications and a few books, of which *Week's* and *Jerry Morris's* were the most important, I conclude that truly classical writing remains fortunately rare but essential to the continuous and practical innovation which should keep up with the accelerating advance of medical science. The Burlington randomised controlled trial of the performance of primary doctors versus primary nurse practitioners³ posed a question which, in times of approaching medical unemployment, is all too easy to evade: what is the functional (rather than social) difference between doctors and other health workers? I suspect that the answer ought to be: a person trained to innovate from (and contribute to) the generalised literature of medical science, to a real, specific population, in a real, specific situation, whether in a hospital or a community (but not the community; there is no such place). No doubt this definition would exclude many general practitioners today, but there is still plenty of time for them to drop the comics, brand names, and branded thought before anyone applies such a test; if, indeed, anyone ever does.

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ONE HUNDRED YEARS AGO The papers now appearing in the *Freeman's Journal* give a terrible description of the misery and want from which the poorer people of some parts of Ireland are at present suffering. Whole villages are desolate, and men, women, and children have died, and are daily dying of starvation and cold. Again the Irish potato-crop has failed, and again, with its periodical persistence, famine stalks through the unhappy land. A fortnight ago, the *Freeman's Journal* published a notice to the effect that an organised national effort, on a sufficient scale, should be forthwith made, to induce the peasantry of the sister island to cease their uncharitable opposition to the importation of wheat and corn, and sorely failed them, as their staple food, and to teach them to transfer their allegiance to the hardy and wholesome oats of the Scotch, supplemented by the rich wheat of the English and the Continent. We desire to support the eminent Dublin physician in his endeavour to ameliorate the sad distress of his poorer countrymen, although we recognise the almost insuperable difficulties of what is asked to be done in his effort to change suddenly ancient and cherished popular domestic habits. Long ago, the famous political writer, William Cobbett, saw that, in the nation of Ireland, the peasantry found the cause of much of the national distress. He wrote: "Whoever wishes to save the country must urge abandonment of the potato for cultivation of the pasture-land, which alone is suited to the climate." He condemned the "cold, wet, sloppy preparation of the potato," and predicted that the treacherous tuber "will be the ruin of our prosperity in Ireland." (*British Medical Journal* 1883; 2: 262.)

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