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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, and no central heating. There was overcrowding. Many had landlords who do 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

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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 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.

Unfortunately this did not always bring commensurate financial rewards. It is true that there was usually a levelling of patients able to pay proper fees. Nevertheless, so much had to be done for those literally on the bread line, such as families of unemployed discharged service men or of those breadwinners suffering from phthisis, that a lot of the work was charity. The phrase "I will pay you on Friday" was accepted for what it was worth. To make matters worse National Health Insurance contributions were reduced in 1922 from 11% to 9%. The battle for improved social conditions, for proper medical care for the lowest paid, and for better conditions and proper remuneration for doctors was to go on for a long time, but that is another story.

ONE HUNDRED YEARS AGO It is proposed, in consequence of the number of deaths which are occasioned by colds caught at funerals, that shillings and guineas 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 practical and generous. 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 tried 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 it 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, 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, in those days all the journals were serious, because we paid for them: the medical comics had not been invented.

Peak flow rates

The next big journalistic event I can recall was Ian Gregg's paper on the distribution of peak expiratory flow rate 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 Glyncorrwg and had only 500 patients. Archie Cochrane, horrified by my news from the practice 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-grandmother 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. Grandmother 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 grandma 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. I was not at all but even more of 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 Platt 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 Pope to Pickering's Galileo. Pickering won hands down, but his victory was not as glorious as undebated. Perhaps his 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 common sense, a new common sense, rather than communication in doubts. 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 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 whole 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 practitioners² 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, signed by a man who called himself 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 unworthy and ungenerous and miserably failed, as their staple food, and to teach them to transfer their allegiance to the hardy and wholesome oats of the Scotch, supplemented by the wheat and barley of the English. 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 seen to be a contest 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 were 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; 3: 262.)

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