Papers That Have Changed My Practice

Diagnostic behaviour and prescribing

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If the title of this article had been "Vividly recalled experiences in practice" or "Great sporting occasions I have witnessed" I might have approached the subject with more relief. Attempts to review scientific papers that have had a notable effect on my day to day practice led to the rapid onset of the "blank page syndrome." Few names or articles spring immediately to mind and this reminded me that people alter their behaviour by degrees and change is a catalogue of tiny refinements influenced by a variety of people and events. It raised the question of how I approach the reading of scientific papers.

If I was to be stranded on a desert island I would probably remain reasonably up to date if I was left with a few standard texts and a recent edition of the *British National Formulary* and would be able to continue to practice provided I was rescued within a year or two. What would I miss by not dipping into the range of publications that now drop through my letterbox? Critical thinking is part and parcel of our professional life and the ability to follow an author's argument is enhanced by reading about medical practice. If knowledge about a subject becomes of secondary importance the ability to have a constructive debate about treatment would disappear and decisions taken on the basis of beliefs and prejudices.

Soon after entering general practice I was overwhelmed by the variety of aches, pains, and problems of living that faced me. Symptoms of respiratory illness were well to the fore and drugs were liberally prescribed, wheezy bronchitis received a combination of broad spectrum antibiotics and various cough medicines; consultations for anxiety and insomnia more often than not ended up with the issuing of anxiolytics and sedatives; and patients with ill defined symptoms and signs left clutching prescriptions for antidepressants, analgesics, or anti-inflammatory agents. I defended this policy by claiming that prescribing in a seemingly haphazard way provided an opportunity to experiment with a large number of drugs, but I was alarmed by the finding that I was using up 300 drug preparations in any one year.

The years 1973-5 seem to have been a crucial time in my development as a general practitioner. I was reasonably well established in practice but not yet long enough in post to be set in my ways. I was fortunate in being able to welcome students to the premises and had become a trainer, but what was I going to teach and what methods was I going to use in my teaching?

Deciding priorities

In 1974 Thomas provided evidence that three in 10 patients were not ill in the acute sense of the word, but were being poorly dependent and required only reassurance and support.¹

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The author made a plea not to attach diagnoses or try to complicate matters by delving too deeply into the determination of consulting behaviour when no objective evidence of physical or psychological illness was present. The evidence provided by his study gave me the confidence to pursue a policy of non-intervention in up to 20% of the patients who consulted me, and this resulted in my practice workload falling and left me more time for patients who required continuing care and also more time to pursue special interests in medical practice.

In the same year Howie had shown by the use of simulated histories that diagnosis and management in general practice are not necessarily sequential and his findings questioned the concept that diagnosis has always to be a forerunner of decisions in the management of ill defined conditions.² Precision in diagnosis is not a feature in many general practice consultations, and diagnostic terms are often used to justify the drugs which we prescribe. The findings of Thomas and Howie helped to remove some guilt that I may have had about not practicing medicine along traditional lines and helped me to explain the nature of my work to students and trainees. Explanation on the basis of good evidence is necessary for the teacher of medicine and the influence of Thomas's and Howie's research came when I was wrestling with the problems of deciding priorities in clinical care and teaching. In clinical care I began to intervene less and adopt a "wait and see" policy. The description of the temporarily dependent patient confirmed that my approach was unlikely to be detrimental to the patient. In teaching I now had a better framework for discussing the process of decision making.

Antibiotics and antihistamines

Respiratory tract infection is a specific area of general practice where in the last decade my clinical care has altered. In 1975 a visitor from Australia left me a reference that showed by use of a controlled trial that antibiotics were no better than placebo in relieving symptoms of minor respiratory illness in children.³ This proved to my satisfaction that in general it was not necessary to use antibiotics for symptoms of upper respiratory disorders. A subsequent study from "down under" also showed that any benefits in the use of antibiotics in presumed viral respiratory tract infection in children were marginal.⁴ These studies have probably resulted in a major change in my prescribing habits but have been a constant reminder to me about the need to be cautious in the use of antibiotics.

Around this time I had also found that I was prescribing decongestant antihistamine mixtures on half the occasions when children presented with upper respiratory symptoms and was also aware of a tendency for ear, nose, and throat consultants to recommend the use of these preparations in children with middle ear problems. I went along with this policy of my specialist colleagues but could find little evidence to support this approach. A two year spell in the United States exposed me to published work in America, and Olson and his colleagues

First Five years in Practice: the 1940s

Before and after the "appointed day"

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The work of the family doctor follows a pattern that in a general way seems not to have changed much during the past 80 years. Such change as has occurred seems to have derived from the great advances in medical science—the conquest of the infections, insight into the nature of inflammation and the immune reactions of the body, the drug treatment of psychiatric illnesses, and the striding advance of surgical technique. All of these have affected hospital medicine more than general practice, which still deals with the apparently humdrum problems of patients' reaction in their lives and relationships to their illnesses, whether grave or transient. Nevertheless, my generation of doctors—I qualified in 1938—have lived through changes of a different, more social kind occasioned by the war and the introduction of the National Health Service, as well as the dramatic technical advances of medicine.

During the war many of the younger general practitioners were called up, and their practices were looked after by their older colleagues in their absence. Their interests were jealously guarded by the profession, and it was difficult for newcomers to general practice to start up except by securing the succession to an established practice, and then only if they were exempt (usually because of medical unfitness) from being called up for service. Those established before the war returned after demobilisation to a practice of the one they had known and worked. Many of their older patients had died and many others had moved, while no new additions had accrued in their absence.

Demobilisation was by no means immediate after the end of hostilities in August 1945; returning doctors had no prospects. Adjusting themselves to the postwar changes than they had to face the introduction of the National Health Service on 8 July 1948 as well.

Many decided to give up general practice to enter the public health service, or to exploit specialist skills developed during war service. Because of the moratorium on entry into general practice many young doctors who had qualified just before or during the war continued to work with their older colleagues. Being older, because of these delaying influences, many of them were married and had started a family, thereby reducing their mobility and personal freedom of choice. Before the war doctors usually married much later than they do now and so were freer to follow the demands of their careers. Moreover, competition was keen because many applicants sought vacancies that were all too scarce. Thus I was 34 when I started as an assistant in a London practice and in married with two children. And I was already 37 by the time I became a principal in the National Health Service with my own rather small (1200 patients on the list) single handed practice in succession to a doctor who, after returning from war service, moved into public health work.

In 1957 I was able to take a partner who entered into family

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practice at the age of 26. All my partners since then, with the exception of one who came to us after several years in hospital psychiatry, have started in their mid 20s.

I started in general practice in July 1947—just a year before the "appointed day" 8 July 1948, which inaugurated the NHS. I was an assistant to a London doctor who had a large "panel" practice and a considerable private practice as well. My task was to look after the panel patients, during the twice daily surgery and the visits, night calls, and the weekends; Wednesday afternoon was my half day. Assistants were modestly paid, and assistantships were hard to get; I was considerably overworked but I gained an immense amount of experience.

Many people, including some doctors, seem to think that there was no such thing as a free medical service before the NHS came in. If this were so, 8 July 1948 would have caused an immense upheaval. In fact the change from the old National Health Insurance scheme to the NHS was a change in the daily pattern of general practice. The National Health Insurance Act was conceived by Lloyd George in 1909 and came into effect in 1911. To my father's generation of doctors it must have seemed far more revolutionary than its successor of 1948 did to us. The National Health Insurance Act required all employees whose earnings were below a certain figure and their employers to pay a weekly sum (in the form of special stamps) to one of the insurance companies that were "approved" under the Act—such as the Prudential and the Liverpool Victoria, whose names are still to be found on the notes of elderly patients. Those insured were thereby entitled to free consulting in medicine and surgery and sickness benefit when they were off work through illness. This meant that most men and most unmarried working women had access to free treatment. Married women who did not go out to a job and children were not covered, and they had to pay their doctor. The fees, however, were not burdensome—about one shilling (5p) for a surgery visit and half a crown to three shillings (12p to 17p) for a home visit, and the service was never withheld if the fee was not available. When illness required several repeat visits, and so might have caused hardship, one could pretend that one "just dropped in because one happened to be passing." Patients sometimes, however, saw through these ruses and didn't like them: "Oh, come on, doctor, we're not that poor!"

We were much more poverty conscious in those days. Investigations on diets between the wars, especially the work of Sir John Boyd Orr (*Food, Health and Income*), made us aware how widespread deficiency nutrition was. When illness required death and morbidity rates of poorer people. In the casualty outpatient departments in the late 1930s we used to prescribe a lot of cod liver oil and malt, nominally as medicine, but actually as food to the very poor. The NHS married women and children came into free medical care, and all the discomforts of charging went by the board, to our great relief. But these patients who then came on to our panel lists were already well known to us because we were then, as now, only too aware of the need for the fee paying that changed—and all the tireless logging them up which was necessary for accounting purposes. The NHS also brought in salaried people and their wives—people whose

from the Rochester Collaborative Research Group showed that pseudophedrine was no better than placebo in treating and preventing serious otitis media.⁶ A further influence was the report from Randall and Hendley, who found that the use of oral decongestant antihistamine mixtures did not benefit in the prevention of otitis media in young children with colds.⁷ These American studies made me seriously question my use of these popular remedies for coughs, colds, and symptoms of middle ear effusion and my use of such preparations has gradually been reduced. There is probably a small group of children with proved atopy who may benefit from these drugs, but evidence to support this is hard to find.

Asthma

With regard to lower respiratory tract disorders, a leading article in the *BMJ* in 1973 brought to my attention the importance of recognising the clinical course of asthma and wheezy bronchitis—terms that continue to be controversial in general practice.⁸ A later report from general practice found that viruses were isolated in one third of children with wheezy bronchitis and most episodes were in children with a pre-disposition to wheeze and many of these children had never been observed to wheeze in the absence of signs of respiratory infection.⁹ Before reading this article my routine treatment for wheezy bronchitis had been a combination of broad spectrum antibiotic and decongestant antihistamine mixtures. The evidence about the role of viruses in aetiology and the importance of recognising the associated obstructive airways in these children led me more towards a policy of using bronchodilators with or without antibiotics and ensuring that assessment included the use of a peak flow meter.

A review of my prescribing has shown that 10 years ago children with lower respiratory tract infection accompanied by bronchospasm had nearly all received an antibiotic and few had received a bronchodilator. I now find that only half the children will receive an antibiotic and approximately three quarters a bronchodilator. As attacks of wheezing are among the most common symptoms in children, the need for a controlled trial of bronchodilators in wheezy bronchitis is long overdue.

Special interests

I have touched on only a few of the articles that I can remember having an effect on my clinical practice and they tend to reflect my own special interests. It is interesting to me to note that over half the papers that I have mentioned have come from professional colleagues with whom I have worked or had contact over several years. I consider myself fortunate to have had the opportunity to read their work and also discuss with them the implications of the conclusions they have offered.

Other reports from general practice have probably influenced me to a greater or lesser extent, such as studies of drug prescribing, treatment of myocardial infarction, and policies for preventive care. Reports from Bristol¹⁰ and Teesside¹¹ may have tempted me to keep more people at home with myocardial infarction, but the numbers seen in any one year are small and I have not accumulated sufficient cases to show any measurable change in my behaviour. The plethora of advice about the treatment of hypertension has probably not resulted in many changes in my approach to patients with raised blood pressure, where I tend to retain a conservative policy. The policy of routine surveillance of preschool children is worth while has led me seriously to consider modifying plans for child care. Experience of developmental screening in general practice has convinced me of the value of preventive care, but I still have doubts about the number of routine examinations recommended and questions remain to be answered about who are the best equipped health care professionals to assess child development. Recently the H₂ receptor blocking agents for treating peptic

ulcer have been supported by some well conducted studies, but in this topic I tend to be influenced by local consultant opinion.

Other habits have changed over the years but to what extent this has been a result of both reading and discussing matters with colleagues is difficult to judge. Few, if any, articles have led to an immediate change of policy, and there are often warring lines between what is acceptable or unacceptable in medical practice. The exhaustive improvisations out of which decision making is distilled are often bedevilled by an endless recycling of competing ideas. As a general practitioner I am striving to find a balance between well informed and being in a permanent state of overload and stimulation.

Despite the advent of instant advice from glossy new medical magazines and video tapes, I retain an enduring interest in the results produced by those who have attempted to find an answer to problems that I am likely to face in patient care. The fleeting hour is the constant enemy of the practising doctor and reading has to be selective, but one of the enjoyments of medicine is responding to new evidence on which to base clinical judgments.

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ON PUERPERAL FEVER Before we discuss the subject of contagion in puerperal fever, we will quote an anecdote which has been related to us by one of the parties. A general practitioner, in one of the neighbouring villages of London, applied, twenty years ago, in great agony of mind, to one of the leading—indeed most eminent—accoucheurs of the metropolis, not more remarkable for his skill and long-extended experience, than for his candour, friendly disposition, and humanity, for advice under the following distressing circumstances. He had lately attended several cases of labour, and had just been visiting a patient of puerperal fever. The poor man dreaded the very idea of another labour, and was preparing to quit the place in which he long had practised. What, under such distressing circumstances, was to be done? "I'll tell you, Mr. —, says the accoucheur: go home, and make a bonfire of every rag you possess and get you new clothes." Some time after this, the accoucheur was surprised to hear himself addressed in the style of an acquaintance by a person whom he thought he did not know. "Sir, said the stranger, you recollect without doubt giving a singular advice (meant to imply) to a general practitioner on the subject of puerperal fever. Well, to be sure I do, very well. — That practitioner I am, I did then as you suggested, and never had a case of puerperal fever afterwards." Dr Campbell, *loc. cit.* On Puerperal Fever. *Critical Review, London Medical and Physical Journal* 1823; 36: 495.

income was above the National Health Insurance ceiling. Many, however, chose to remain as private patients at first. In the practice in which I worked we had 1000 patients on the list, and this rose to 2000 after the appointment. By the time I left, 18 months later, there were more than 4000.

Unofficial training

In those days there was no official training for general practice, but the casualty outpatient departments before 1948 were a good unofficial training ground. Casualty officers dealt with fractures and accidents and also had long surgeries sometimes going on into the afternoon in which women and children considerably outnumbered men. Casualty officers got to know their patients well, just as family doctors do, especially if their appointments were prolonged. They dealt with the familiar ailments of general practice, and their patients were mainly women and children who preferred the free hospital treatment to going to their husband's doctor and paying the nominal fees. It is often forgotten that hospitals in Britain have always provided free treatment. The mediocrity of St Bartholomew's Hospital ensured free provision of medical care for the "deserving poor." I doubt if the "undeserving" who were there, were excluded in recent centuries.

Lloyd George's Act was revolutionary because it provided the means whereby the freely contracting family doctor could be paid, not by the patient. And medicines and sick pay also became free. But even before the National Health Insurance Act had brought free treatment to most of the working population there were the "doctors' clubs" and the sporadic insurance schemes set up by the insurance firms before they became "approved societies." Even today patients will sometimes ask for a sickness certificate by saying "Can I go on the club, doctor?"

The NHS was immensely welcome in family practice because it made free service available to the whole population, and abolished fees for all but exceptional, special services. In hospitals its effects were in some respects the reverse. Before 1948 consultants in the teaching hospitals were not paid; they were honorary consultants. In the municipal hospitals they were salaried, and usually excluded from private practice. It was expected that an honorary consultant would give his hospital patients exactly the same care and expertise as he gave to his private patients, and tradition ensured that he did. I knew a surgeon who all his life suffered from bronchitis, and the hospital management committee reminded him, rather pointedly that his appointment was renewable annually.

Many consultants did enormous outpatient clinics, and

waiting lists were virtually unknown. After 1948 consultants were paid on a sessional basis, and this required that a session be defined; no more than so many patients, of whom no more than so many must be new patients. For a number of the older consultants this changeover must have been strange and a limitation. Under the "honorary" system waiting lists did not seem to build up.

Pressure on the hospitals has increased enormously and has led to another form of restrictive practice, the concept of catchment area. Brought in originally to deal with emergencies, and always resented by the family practitioner committees, it has become an accepted arrangement. Older doctors look back with nostalgia to the days when they could refer their patients to the hospital and the consultant of their choice. Indeed, they are entitled to provide the best treatment for their patient in the family doctor's terms of service.

Pressure on consultants has in some areas been relaxed, however. When I was first in practice investigations except chest x-ray examinations could be obtained only by referring the patient to a consultant. Open access to pathological and other investigations to family doctors must have relieved consultants of a great deal of work, and it is now difficult to remember what general practice was like without access to services that today are regarded as essential.

The NHS took over from the National Health Insurance unchanged the way in which family doctors were paid. This was by a "capitation" fee for every patient on the list. This meant that doctors were paid more for a large list than for a smaller one. If you had a huge list (the maximum permitted was 4000, later reduced to 3500) you were relatively well off; while a doctor with a small list had more time to spend on his patients, but was paid less for so doing. Furthermore, all practice expenses, such as rent, equipment, and ancillary help, had to come out of the total of capitation fees. There was a financial incentive to spend as little as possible, indeed to do as little as possible for your patients. Looking back, it seems to me that general practitioners deserve great credit for the devoted way that they looked after their patients under this system of payment. It may be that the change in this system under what was called the "doctors' charter" in the middle sixties was the most important factor in making it possible for general practitioners to provide the different, and much improved, service that they give today. But it is a fact that the attitude of most doctors to their patients was of a high order under the National Health Insurance Act, the early days of the NHS, and these latter years during which general practice has undergone a renaissance of a most striking kind. The social vision of Lord Beveridge, of Lloyd George, and of the great social reformers of the nineteenth century, like Lord Shaftesbury, could hardly have been translated into present day reality without this tradition of doctors themselves.

Diary of Urban Marks: 1880-1849

In regard to the Boilemakers, there was no difficulty at all in getting them transferred to me. In this club the benefit was for men only but naturally the women and children were paid privately. I used to charge half a crown for a consultation and medicine in the surgery and five shillings for a home visit. I was doing fairly well at that time until one Sunday I suffered from a bronchitis. I was brought into the surgery. After diagnosing the case I charged the usual 2s and said I would call round in the morning as the child was too ill to go outdoors. But my mother said that I need not trouble because my fee was too high and she would call in Dr Anderson who only charged 1s in the surgery and 2s per visit. I promptly went to Dr Anderson, who was my only rival of any account in the district and asked him if this was true. He admitted it and

said that those were the fees appearing for many a year past. I protested that such fees were prostituting the profession and asked him to raise the fee to my level. He maintained that it was absolutely impossible and people would not pay it. I insisted that if we both agreed people would have to pay the fees demanded but all my talk was of no avail. I left him in disgust but kept my feet to the level I had set. I did very well but perhaps I might have done better. The result was that the better class people in the district came to me while Anderson attended all the rest of the district. I did less work for more money comparatively than what he did, but although I say so I do pride myself that my work was of a far better quality than his. I never kept stock medicines like he did and I always bought the best drugs in the market.