PRACTICE OBSERVED

Interesting GPs of the Past

Urban Marks: 1880-1949

DAVID STUART

"The door of the large room in the College of Surgeons was suddenly opened to reveal a commissioner—largely built—in full uniform—medals across his chest and a bunch of pink papers in his arms. The crowd of medical students, who a moment before had been extremely boisterous with forced hilarity while waiting for the result of the examination they had just completed, became silent. An uneasy hush prevailed to be broken by the stentorian voice of the commissioner.

"Number 121, he called. Leapingwell, my great chum, walked through the crowd. 'You are through, Sir. Please go upstairs'.

"Number 122. Sorry, Sir.' Very politely the commissioner took a pink paper from his bundle and handed it to the unfortunate fellow. With a white face he faded away.

"Number 123. I walked forward. 'You are through, Sir. Please go upstairs.' I was so surprised that I said 'Are you sure?' 'Don't ask any questions Sir. Please go upstairs'.

"I joined Leapingwell on the stairs and we mutually congratulated each other. Upstairs the room was filling up with the successful candidates and soon the commissioner announced that all were present. The president of the examining board took his place at a long table decorated by the mace while the other professors sat around. The president then congratulated us as a whole and proceeded to administer the Hippocratic Oath. After this he launched into a lecture on the duties we owed to ourselves—to our colleagues and to the public, exhorting us over to behave as doctors and gentlemen. Finally, after shaking hands with each of us individually, we signed the certificates and the roll. We were now free to make or mar our lives as Fortune willed. In one moment from gay, irresponsible young students we were turned into grave old

men charged with a responsibility—the welfare of mankind. Life and death were in our hands. There was not one of the newly qualified men who left that room but did not feel the onus laid on him. Actually the time of our release was 12.30 pm on the morning of October 23rd 1905."

I never met my great-uncle, Dr Urban Marks, and knew nothing about him until his life diary of over 100 pages, laboriously typed, apparently written in sections during his working life and after retirement, appeared from the bottom of a distant cousin's drawer. It contained a wealth of information which enabled the construction of an accurate family tree, but above all, vivid descriptions of episodes in his professional life.

His grandfather, a German Jew, had emigrated to England in the early nineteenth century. The family were fruiterers in Hull and Leeds until Urban's father moved to Leicester when he was 5 years old. From the Wyggeston School he obtained an exhibition of £25 to St Mary's Hospital in 1899, supported by his father, who paid his keep.

"I was allowed 7/6 weekly for pocket money and out of that I had to find tea which cost a penny in the students' club. Cinemas were of course unknown and I could not often go to a music hall or theatre. When I did so it was up in the gallery for 1/- . We thought we were leading a gay life if on a Saturday night we dined at Lyon's Popular Cafe which had just then opened—for 2/6—and then went to a show for 1/- winding up by having a couple of lagers in the Cafe l'Europe in Leicester Square for 8d."

"Across the road there were the Cavour—the famous Leicester Lounge—and a place under the pavilion where a negro band played ragtime—the forerunner of jazz today. All these places were open until 12.30 am and as the underground railways ceased to run long before that it was not uncommon for us to walk home."

On qualifying he had hoped to become an eye surgeon, but

Great Yarmouth, Norfolk NR30 4ER
DAVID STUART, MB, FRGP, general practitioner

to begin with, presented to him by a colleague whose practice he cared for during a spell of inebriety. As the practice increased it became more difficult to cope and eventually he bought a 2-cylinder 10-horsepower Darracq in 1911, costing £105 secondhand.

"Saloons were unknown except on the most expensive cars. There were no side doors and with a Cape Cart Hood the draught even at a small speed was tremendous. Soon after I had purchased the car I was taught to drive by a man called Boyle who took me on the Mumbles Road and told me to get on with it, always remembering that there was a bigger bloodier fool than myself on the road. The roads of years ago were not too good. Some had holes in which one could camp out for the night with comfort. Now they are like velvet no matter where one goes. Sparking plugs do not now sputter up and stop the car. Springs do not break. Tyres do not split to atoms and punctures are very rare. All these occurred at first and added to the joys of a journey, especially if any one of them occurred miles from a garage, which were not so numerous as they are now. Petrol filling stations were unknown and one had to carry spare tins of the stuff for fear of running out. Carburettors leaked and one never knew where one would get to at the end of a day's run."

He ran the Darracq for two years and after a short unhappy spell with a Phoenix bought a Buick with electric lights—a rarity in those days. He employed a mechanic-chauffeur called Kneath, "who at the time knew nothing about a motor. He

had, however, a mechanical turn of mind and through the years taught himself all there was to know about a car. He has been with me now for 20 years and can take a car to pieces and rebuild it. He will have a few nuts and bolts left over but the car will go just as well as before it was dismantled."

Between the wars his practice life was busy but happy, though his first wife May died in 1926 and his second wife in 1938. He had been friendly with the matron of Swansea General Hospital, Miss Agnes Duncan, and they married just before the outbreak of the second world war. Though now over 60, in 1941 he and his third wife took charge of the Convalescent Hospital operated jointly by the Order of St John and the Red Cross, and continued to work there until his retirement in 1946, caring in all for over 2200 patients.

By many, great-uncle would be dubbed a "workaholic." At his prime, between 1922 and 1925, he ran a large practice with 175 confinements annually, was commissioner for the SJAB, was on the Board of Guardians, and was chairman of the local BMA, the Panel Committee, and the Insurance Committee, as well as being secretary of the Medical Service, together with conducting a very large practice. "I begin to wonder how I survived. Yet I did, and at the moment 10 years later I seem no worse for all my activities. All I do notice is that I am not the fiery youth I was nor am I so sarcastic, but time mellows everything and arteriosclerosis would have developed even if I had led a quiet life!"

He probably did survive because he enjoyed it all so much, and that must be the lesson I have to learn from his diary.

Practising Prevention

Coronary disease

JULIAN TUDOR HART

Though angina was common in the eighteenth and nineteenth centuries myocardial infarction was not recognised and was probably rare. The modern epidemic seems to have begun in the 1930s, about 15 years after the first world war. By the 1950s it was by far the commonest single cause of premature death. Post-mortem examinations on soldiers killed in Korea showed that even in men of average age 22 gross coronary atheroma was already present in 77%.¹ Mortality from coronary disease continued to rise after the second world war throughout the industrialised world; between 1951 and 1971 the coronary death rate for men in Britain almost doubled. Coronary disease now accounts for nearly half of all deaths in men before retirement age. As epidemiologists unravelled its major precursors, it began to seem possible that high risks of early death must be an inevitable consequence of general social advance.

Glyncorrwg, West Glamorgan SA13 3BL
JULIAN TUDOR HART, MB, FRGP, general practitioner

Coronary disease is not inevitable

This view, which associates high risk with good living and consequently links prevention with a shorn, abstinent, and deprived social condition, is now a main obstacle to serious strategy for controlling coronary disease. Like any effective myth, it contains elements of truth; but in general the concept is false.

This falsity is proved by two incontestable facts. Firstly, within countries (rather than between them) the poor have higher coronary death rates than the rich, with rates 11% above average in unskilled labourers in 1971, and 12% below average in professionals.² Social differences in mortality in the younger age groups are much higher than in late middle age. At ages 35 to 44 unskilled labourers are 55% above the mean for the whole population, and professionals are about 75% below it. These social differences are probably the main cause of the large differences between different parts of Britain, with rates in West Scotland, Northern Ireland, and the South Wales valleys 50% higher than in East Anglia and the home counties (fig 1).³

The second reason for rejecting a fatalistic view is that in the United States and Australia rates fell by more than 25% in the 10 years from 1968 to 1977, despite a continued rise in general living standards in both countries. The reasons for this fall are

the collapse of his father's business removed the necessary financial support and he determined to enter general practice. As a first step he applied for the post of house surgeon at Swansea. He went for interview. "Never shall I forget my first impressions of Swansea. It was a cold, bleak December morning and dawn was beginning to break as we reached Landore. All the works in that district were in full swing. The smoke and glare of the furnaces made the place look like Hell itself. But beggars cannot be choosers and although I had half made up my mind that I could never live in such an atmosphere I proceeded. I had donned a frock coat which was not in the best

fee of 2/6 and providing confinement care for a guinea, the practice income rose from £300 to £800 in three years. Some of this was gained from home surgery, particularly tonsillectomies and hernioplasties. The fee for the former was 2 guineas with 'half a guinea for the anaesthetic; for the latter major procedures the fees were doubled. At the other end of the financial scale was the care of furnacemen for Messrs Baldwin, where the workmen paid "threepence a week for themselves and their families, the money being deducted from their wages and paid to him monthly."

"I had been living a very quiet life and devoting myself to building up a practice when in 1911 came the rumours of a National Insurance Act. The British Medical Association at that time had no political department and its headquarters staff rather lost its head. Not half of the practicing doctors were members of the Association. Divisions of the Association had been recently formed in all large areas and these were subject to the branch council, although each division had its own executive body. The reorganisation had only been in existence about three years previous to which each town or village had its own medical society at which scientific papers were read and cases were shown. The offer of the Government was 4/6 per panel patient per year but no drugs were to be provided by the doctor. This sum did not seem sufficient to the heads of the Association, and divisions were urged not to accept this sum. A demand of 7/- was put forward, together with the famous six cardinal points the chief of which was that there should be free choice of doctor and the doctor should have free choice of patient. Meetings were held constantly to discuss the various matters as they arose. These went on merrily until Christmas of 1912 when the news came that Dr Whitaker, who was the principal secretary of the Association, had joined the Insurance Commission which had been set up to work the Act. Many of the Association members felt that they had been betrayed and resignations from the Association were sent in wholesale. Finally, on New Year's Eve of 1912 there was a huge meeting at the hospital in the board room. The place was crammed out and there was not enough seating accommodation. The situation was discussed by both sides, the ayes and the noes. To the last minute we had been urged to refuse to work the Act. Dr John Adam Rawlings, who was a great Liberal, got on a form and addressed the meeting. He professed to have inside knowledge that if we did not accept the Act Mr Lloyd George was prepared to put doctors who would do so into each area. I then asked the Association members if we had any strike funds, pointing out that if for one did not join the panel I should be starving in a few days. I had no resources behind me and unless the other members were prepared to support me I had no other option but to go on the panel. I could not see my wife and children starve. I was not afraid of Lloyd George's doctors being dumped into the town as they could not possibly work the Act. However, without strike funds our position was hopeless and I therefore proposed to put my name on the panel when day broke. It must have been in the neighbourhood of midnight when the meeting broke up but nearly every doctor was on the panel early next morning."

Urban Marks became secretary of the local medical committee and occupied office in the local medical committee and the local British Medical Association continuously for many years with a short break for National Service in 1917-19, spent in Mesopotamia. He was on the special commission of the BMA from 1941 to 1944 which studied the wartime and postwar provision of medical services, and which helped to frame the National Health Service. In addition to all these duties he continued to work for the St John Ambulance Brigade, becoming commissioner for Swansea and a Commander of the Order of St John in 1927, and a Knight of the Order in 1937.

In an age of good roads and reliable motor cars it may be difficult to visualise the discomfort of getting about a practice in those earlier times. Urban went about on a Sunbeam bicycle

of condition considering that I had had it since my mother's death. It was inclined to be on the green side. My top hat was not new by any means, being as old as the frock coat. An umbrella and kid gloves completed my outfit. As I came out of the station so equipped I must have looked like Guy Fawkes to the casual passer-by." On arrival he discovered that the other short-listed candidate could not come for interview. "My frock coat and top hat so paralysed the Committee that they unanimously elected me to the vacant post" at a salary of £50 a year.

He worked for a year in Swansea, and for a short time in Worcester as a junior house surgeon, which was not only surgical and ward work but also the care of the casualty department and giving anaesthetics when required. In August 1907 he became a ship's doctor on a Blue Funnel Line ship, the *Jason*, and worked a round trip from Liverpool to Shanghai, via Singapore and Tokyo. The pay was £8 a month (with a bonus of 1/6 a day for satisfactory behaviour); he provided his own surgical instruments and dental forceps. At Singapore a friend "took me to the English Club and when I remarked on the amount of whisky the younger men could make disappear in a short time he said that I ought to see the cemetery. Most of the drinkers were remittance men, men who were paid by their families to remain out there. The average age on the tombstones was 27 and no wonder. The glasses used were very large, double the size of an ordinary tumbler. There was no duty on whisky out there and a "whisky stinger" consisted of more than half an ordinary tumbler of whisky diluted with soda water."

He then returned to Swansea and bought the practice of Dr John Davies at 1 Trinity Place for £140. The practice cared for the lodges of Shepherds and Boilermakers, with a guaranteed income of £75 annually. Charging a consultation

FIG 1—Death rates from ischaemic heart disease in men aged 45 to 54, standardised for population of England, Wales, and Scotland, divided into quartiles. Reproduced with permission from Fulton et al. *Br Heart J* 1978;40:566.

still poorly understood. It long precedes mass use of coronary care units or coronary bypass surgery, and even the widespread use of antihypertensive drugs probably contributed little until the mid-1970s in the USA, but the trend does coincide with falls in cigarette consumption and a rise in consumption of polyunsaturated fats.⁴ Caution is necessary before concluding that Britain's persistently high rates are attributable to our medical conservatism or the relative poverty of our health service. Rates are stationary also in Sweden, despite excellent high technology services and falling consumption of saturated fats, and rates in American women are falling despite their rising consumption of cigarettes.⁵ Both American and Australian rates were a third higher than British rates in 1968, and even now are at about the same level as ours. We still do not know all the major causes of coronary heart disease and sudden heart death, and some of these trends are inexplicable in terms of known risk factors. They do prove, however, that coronary mortality can fall without a nationwide turn to a monastic life.

What can and cannot be done in general practice?

The principal known risk factors for coronary disease are cigarette smoking, hypertension, and hyperlipidaemia. There is now no reasonable doubt that these factors are causal and that their control can have some effect on coronary mortality. Other possibly important risk factors are the absence of regular vigorous exercise, having an aggressive and socially ambitious personality, and sustained social or emotional stress. The last two are difficult to define. Nearly all the evidence comes from the USA and may not apply here. Furthermore, there is little convincing evidence that they can be controlled, or that such control reduces the risk of coronary disease. British general practitioners, particularly those in the poorer industrial areas with the worst mortality from coronary disease, have to work very hard at dangerously high speed even to meet the wants of their patients without searching for unmet needs. Any effective strategy for controlling coronary disease in general practice must satisfy two conditions:

- (1) Only a few, simple tasks must be required, whose effective-

ness must be thoroughly validated by controlled trials. We do not have the time to pursue policies merely because they are rational.

(2) These simple tasks must be made available to everyone at risk in our registered populations, by an active outreach policy.

Only four measures pass this test, all with substantial reservations.

CIGARETTE SMOKING

In Doll's study of British doctors' men who stopped smoking between 34 and 55 years of age reduced their coronary mortality by half in five years, compared with doctors who continued to smoke. Stopping after 55 made much less difference. About half the benefit of stopping is reached by the end of the first year.⁶ The degree of risk is closely related to the number of cigarettes usually smoked,⁷ but filter cigarettes are probably not protective.⁸ Cigarettes have a synergistic effect on arterial disease with the oral contraceptive pill, increasing the risk of coronary disease (obviously small in young women) twenty-fold.^{9,10} Stopping smoking after a first infarction is the only measure definitely proved to reduce subsequent mortality from coronary disease, again by about 50%, compared with those who continue to smoke.¹¹⁻¹⁴

So there is no doubt about the effectiveness of stopping, particularly in young men and women. There is much more doubt about the effectiveness of GPs in achieving this end, and more still of their willingness even to attempt it, at least until recently. We are only beginning to learn how to extend the ordinary consultation (for whatever complaint) to include personalised advice on smoking and how to assist people who want to stop, because we are only beginning to try. The least we can do is to organise our work so that we know the current smoking status of all consulting patients.

HYPERTENSION

Arterial pressure sustained at or above 100 mm Hg (phase 5) through three separate readings should be treated because there is good controlled evidence that this reduces mortality¹⁵ when treatment is begun in middle age. There is no controlled evidence of benefit from treating asymptomatic hypertension in elderly patients. Most of the reduction is by preventing stroke, heart failure, and renal failure. There is persuasive, but so far not conclusive, evidence that antihypertensive drugs, particularly beta-blockers, can also reduce mortality from myocardial infarction.

Controlling borderline hypertension in the diastolic range 90-100 mm Hg, if it was to delete hypertension as a risk factor for coronary disease (perhaps by starting treatment in the 20s or 30s rather than in mid-life age), would have a far greater potential preventive¹⁶ (and clinical) patrolling moderate and severe hypertension of 100 mm Hg +. This is shown clearly in fig 2.¹⁷ Despite the results of the Hypertension Detection and Follow-up Program in the USA,¹⁸ it is doubtful whether this can or should be achieved by using antihypertensive drugs, which would require life-long medication for 15 to 25% of the adult population. Reducing dietary sodium by a third—from about 150 mmol to less than 100 mmol daily—has now proved effective in controlled clinical trials in hospital outpatients with borderline hypertension.¹⁹ A similar controlled trial in a free-living population is now under way in Glyncorrwg, and it remains to be seen whether it will prove feasible.

Apart from controlling smoking, most of our hopes for future prevention of coronary disease must probably rest on reducing dietary sodium in borderline hypertension. We do not yet know what changes this will imply for general practice, but judging from the poverty of our other taken attempts to influence diet in diabetic and obese patients, big changes will be needed,