Interesting GPs of the Past

Urban Marks: 1880-1949

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"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

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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 Convent 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

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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.

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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 the 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 Boiler-makers, with a guaranteed income of £75 annually. Charging a consultation

still poorly understood. It long precedes mass use of coronary care units or coronary bypass surgery, and even the widespread use of antiplatelet 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 antiplatelet 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 preventive value than treating moderate and severe hypertension of 100 mm Hg +. This is shown clearly in fig 2.¹⁶ Despite the results of the Hypertension Detection and Follow-up Program in the USA,¹⁷ 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.¹⁸ 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,

probably requiring large numbers of elementary nutritionists working in the community as members of primary care teams.

HYPERLIPIDAEMIAS

Severe familial hypercholesterolaemia is rare, causing less than 1% of all hyperlipidaemias. Homozygotes mostly die from coronary occlusion under age 30 unless they are controlled by arduous dieting supported by drugs. With a heterozygote frequency of 1:500, screening of the first-degree relatives of every case of coronary occlusion under 50 would detect children at a treatable stage.¹¹

FIG. 2—Proportions of a screened population of 9538 American men aged 55 to 64 in four categories by mean diastolic pressure, mean of three readings, from the National Health Examination Survey, 1960-62, and the relative risks of myocardial infarction or stroke during one year for the same categories, from the Framingham "blue books." Source: Epstein.¹²

Raised total or low-density lipoprotein (LDL) cholesterol increases the risk for myocardial infarction synergistically with the other major risk factors—smoking and hypertension. The association is high in young men and women and declines with age. High-density lipoprotein (HDL) cholesterol, on the other hand, protects against coronary disease, it probably reflects cholesterol mobilisation, while LDL cholesterol reflects deposits as atheromatous plaque. The protective effect of HDL cholesterol persists in elderly people,¹³ but this fraction is influenced more by smoking and exercise than by diet. Consequently advice about diet needs to be concentrated on people under 50. There is little evidence that specific cholesterol-lowering diets are more effective than diets that aim simply at reducing body weight to within 10% of its ideal level. This can be easily calculated by the formula for body mass index (BMI)—metric weight divided by the square of metric height. BMI should lie between 20 and 25 for adult men and 19 and 24 for women. Triglyceride concentrations, which are also a positive risk factor for coronary disease, are so closely linked to fatness that there is little point in measuring them.

The safe and effective way to reduce LDL cholesterol is to follow a prudent diet, with calories restricted to attain ideal weight, all fats reduced to about 30% of total calorie intake, and more high residue foods. The disadvantages of clofibrate in promoting gall stone formation probably outweighs any advantages. Shifts in dietary habits leading to a reduction of LDL

cholesterol are probably occurring now because of changes in public opinion about the wholesomeness of foods. In 1980 the consumption of sugar in Britain went down by 8%, eggs by 10%, milk by 10%, white bread by 20%, and butter by 22%; whereas consumption of potatoes rose by 23%, margarine by 27%, and brown bread by 41%.¹⁴ All the indications are that people are able and willing to change, but in addition to needing better, informed help from their own doctors, food manufacturers will have to make labels more informative and less promotional. Perhaps as a profession we need to press for the legislation to secure such a change.

EXERCISE

Retrospective studies tend to show lower coronary risks for those who take vigorous daily exercise, though the differences are less than those attributable to smoking, hypertension, or hyperlipidaemia.¹⁵⁻¹⁷ Such people, however, obviously differ from those who make other uses of their leisure time. Controlled prospective studies of exercise programmes after myocardial infarction in people under 57 showed no improvement in survival after four years, though fitness as measured by a bicycle ergometer was appreciably improved, and effort tolerance in those with angina had increased 100%.¹⁸

Regular exercise, however, could have an important indirect effect on other, more potent risk factors by providing an essential part of a more general changed lifestyle emphasising active creativity rather than passive consumption. Much more needs to be done to link primary care with local sports facilities (as in the sitting of health centres at Milton Keynes new town), to assist those who need to acquire or maintain non-competitive sporting activity.

A plan for general practice

Looking at the whole field of atheromatous arterial disease, stroke as well as coronary occlusion, the Royal College of General Practitioners' working party on prevention¹⁹ recommended immediate action on three points for the whole adult population up to age 65: (i) control of hypertension when the diastolic pressure is 105+ (which we would now reduce to 100 mm Hg in the light of the Australian trial); (ii) personalised advice on smoking; and (iii) measurement of weight and height in all who look fat, calculation of ideal weight, and advice and support for those who want to try to attain it. Three further points for immediate action were suggested for subgroups: known diabetic patients should be reviewed for other coronary risk factors, particularly smoking and hypertension, and diet should be reviewed to reduce the total amount of fat; women on oral contraceptive pills should have their arterial pressure monitored regularly and be advised on smoking; and the need for thiazide diuretics should be reviewed regularly to avoid unnecessary use of these eventually diabetogenic drugs.²⁰⁻²²

We have to start from where we are. Half our hypertensive patients are unknown, and half of those who are known are not controlled. Our diabetic patients seem to be equally divided between those who receive interpersonal—and therefore inefficient—advice, and those who see their GPs but receive little effective monitoring, and those who pick up repeat prescriptions but receive no regular medical supervision.²³ Step one for every practice that is seriously interested in preventing coronary disease must surely be to improve the quality of care and follow-up of these two very high-risk groups. Few of them rightly belong in hospital outpatient departments, for their clinical needs are simple—regular monitoring of arterial pressure and serum glucose, and advice on smoking and diet. Patients and regular monitoring of optic fundi, glycosylated haemoglobin, and weight for diabetic patients, and sustained pressure to give up smoking for both. Step two is to ascertain all hypertensive patients by a regular system of case-finding, updated

Organising a Practice

Clinical policies

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In a previous article¹ I discussed policies concerned with the organisation of a general practice. Policies that affect clinical work may be more straightforward and easier to agree on owing to our clinical training. Discussion about managing patients with conditions such as urinary tract infections can proceed along rational lines and consistent criteria required for diagnosis, the cost of treatment in terms of efficacy, side effects, and the outcome with or without medical intervention. As we found in a study in our own practice,² however, agreeing on a policy is much easier than implementing it since practice does so challenges the doctor to question both the appropriateness of the policy and his own clinical performance.

What are the benefits of policies? A consistent approach to management by different partners in a general practice has advantages even in cases of minor medical importance for which there is a range of possible treatments. Howie³ has shown that although doctors differ widely in their management of upper respiratory tract infections, nevertheless in some practices such conditions are treated in a consistent manner, suggesting that a policy exists even if it has not been formalised. Patients who consult different partners in such practices are concerned that they will be confused about their own future management of these illnesses.

Having practice policies is also an advantage in educational activities. Much of the clinical teaching in hospital and in primary care is anecdotal or based on actual cases and is valid only if the particular case is used to illustrate a principle or policy. Medical students and GP trainees frequently ask whether the practice has a policy about the management of clinical conditions. The difficulty that some may have in responding to these questions is an indication of the wide individual variation and clinical freedom inherent in general practice. It also invites the criticism that there is perhaps insufficient discussion between partners in a group practice on the rationale for a particular way of managing patients' problems.

The standardisation of clinical policy is one component of medical audit because it is necessary to agree on appropriate criteria before examining clinical behaviour and assessing the outcome of care. Establishing these criteria and defining the desirable outcomes of care are two of the aims of practice policies.

Chronic illness

Does your practice have an agreed policy about the management of patients with epilepsy, diabetes, or one of the other common chronic illnesses? Is a policy necessary? Published

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evidence⁴ shows that there are serious inadequacies in the care of patients with chronic illnesses. The finding that the attention to such patients is inadequate in hospital outpatient clinics as well as in general practices is no consolation. Effective policies for the management of chronic illness can only be laid down when there is collaboration between the patient, the general practitioner, and the hospital specialist. Before attempting to establish such policies the doctors have first to know the numbers of patients with a particular illness and the pattern of care provided, and then in the light of these findings particular problems can be identified and specific policies developed to meet these problems.

The attitude of the patient is crucial for determining the effectiveness of the medical intervention. In making any rational decision about his future health a patient should be adequately informed about his illness. Similarly, the doctor needs to know of the patient's beliefs about health to make appropriate plans to help the patient. A practical policy may be to make available to the patient written information about his illness and also encourage him to contact the relevant voluntary organisation. In some practices the number of patients concerned with a particular illness is small, and the doctor and information sheet may be held in collaboration with the specialist from the local hospital. In most practices, however, the problem for the doctors is that individually they see only a few patients with each chronic illness. A combined structured medical record and information sheet may help to remind the doctor about the agreed policies of management. The card could also be used as a shared medical record between hospital and the general practice.

Assessment of older people at home

It is well recognised that many elderly people who live in their own homes have some unmet medical needs. These patients tend not to report to the doctor symptoms that they consider to be due simply to growing old. The systematic detection of established symptoms and disabilities in the elderly is most appropriately described as case-finding, since it differs fundamentally from classic screening programmes. Does the practice have a policy about the needs of the elderly? Do all the partners in the practice routinely visit housebound elderly patients? Is the content and purpose of such visits clear? Is this work co-ordinated with that of the health visitor and the district nurse? Do the medical records identify accurately the needs of the patient? Consideration of these questions is the first step in agreeing on a policy as to how the practice can meet the needs of old people. For instance, it cannot be assumed that the most effective way of providing care for the elderly is by making routine visits. Visits could be used to ration services rather than to seek out problems that require attention.

An ageing register is essential if systematic surveillance of

every five years, and to search actively for maturity-onset diabetes by screening fat people over 50 for glycosuria, again using case-finding. This is likely to double work load in both these categories. Step three is to ascertain the smoking status of the whole population aged 12 to 64, and to offer sustained, personalised advice and support in subsequent consultations.

Resources and organisation

Preventing coronary disease requires two big changes in practice organisation. Firstly, means must be found to expand the consultation to include an active search for needs as well as the more passive satisfaction of wants. Now, at least in the over-worked areas where coronary disease is most prevalent, we have an average face-to-face consulting time of five minutes.²⁵ We can do this in three ways: by delegating clinical measurements to employed staff, by taking on more partners whole-time or part-time, and (doubtfully) by reducing time spent on less useful tasks.

Secondly, we have to make regular monitoring of the whole adult population, or of special groups in it, a normal and necessary part of practice. This requires a record system suitable for such use, with colour tagging, structured display of data, and means of readily identifying tasks not yet done. I do not believe that this can be done within the limits of the Lloyd-George record, and the need to change to A4 has to be faced. It also requires staff time, as well as the support and interest of at least one partner in the group. There can be no greater illusion than that computers will bypass the need for good structured records and substantial staff and medical time devoted to their use. To get beyond our present passive response to breakdown and organise active search for need requires a transformation in the way we work that must precede delegation to machines. Until we have mastered the task it will not be defined or understood, and therefore cannot be computerised. The data inputs will be local, personal, and specific, and can come only from our own work; we cannot buy it off-the-shelf as computer software.

Our immediate need is more staff, and this should not be a difficulty. Though GPs are each entitled to employ two whole-time equivalent supporting clinical or nursing staff with 70% reimbursement of wages (and the remaining 30% set against tax), only 15% of all GPs currently employ their full entitlement. The average number of staff employed by GPs in England and Wales is about 1.2. We seem to be up against our own ancient traditions of counting pennies to let pounds look after themselves—all tactics, no strategy. Except in overworked areas, most of us could also add additional medical staff. Preventive work is predictable, crisis-free, and could be planned to meet the needs of the growing number of women graduates who need less open-ended commitment to practice.

Conclusion

The present state of general practice is too variable to permit a cookery book solution for coronary prevention. GPs are the most highly educated health workers in their communities. Each of us must adapt, as best we can, the general conclusions of medical science to the specific problems and resources of our local community. Few of us can as yet do all the simple things that need to be done; but even fewer are truly unable to make a start on some of them—not for some, but for all of the people.

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elderly people is to be attempted. The register will give the total number of patients who might be concerned in a case-finding programme, and the register will also identify individuals. Subsequent examination of their medical records will show how big the work load is from this group of patients, and with this information it should be possible to devise new policies that would make more efficient use of the existing doctor-patient contacts. For example, hypotensive and psychotropic medications are together the commonest group of drugs prescribed for elderly patients. Making repeated home visits to renew prescriptions for such drugs may be inefficient and possibly inappropriate. The strategy used to identify unmet medical needs will depend on the characteristics of the elderly patients in the practice and on the resources of the primary care team. It is possible to be dogmatic about one policy, however: foot problems are so common in old people that case-finding is virtually unnecessary, and all people over the age of 75 years should be offered an assessment by a chiropodist.

Prescribing

A general practitioner's prescribing pattern is one of the most easily measured clinical activities. In addition to the regular analysis provided by the Prescription Pricing Bureau there have been many surveys and studies of prescribing by general practitioners. Marsh¹ showed how a definite policy of encouraging self-medication for minor self-limiting illnesses can be implemented and assessed the impact that such a policy has on prescription costs in the practice and the effect of this policy on subsequent consultation rates for these illnesses.

Several policies for prescribing can be discussed. The doctors could try to restrict the range of analgesics and antibiotics that are prescribed, for example. Such a policy could be of direct benefit to the pharmacist as well as to the Treasury. There will necessarily be many deviations from an agreed policy of this kind, and the reasons for such deviations are themselves instructive and will help to develop the policies further.

The cost of drugs prescribed by general practitioners exceeds their own income, and the emphasis on the huge cost of prescribing is understandable. In addition to the existing analysis of prescribing costs, the new computer analysis provided by the Prescription Pricing Bureau will allow general practitioners to assess their own prescribing of different groups of drugs and will permit the evaluation of prescribing policies in more detail.

REPEAT PRESCRIBING

It is easy to forget how recent is the phenomenon of repeat prescribing. Before 1950 it would have been unusual for patients to receive a prescription without seeing a doctor. Nowadays repeat prescribing is an accepted part of general practice, and systems have been introduced to cope with the numbers scripts required. A sad comment on our times is that computers can now memorise and print the repeat prescription for psychotropic drugs to patients whose problems may be related to job redundancies caused by the introduction of automation. Patients should aim to clarify the reasons for starting to give repeat prescriptions and also to ensure that patients who receive such prescriptions are seen regularly.

A typical system might be: the decision to initiate repeat prescribing is stated on the prescription; a specific card is given to the patient describing the drugs, their purpose, dosage, and time of administration; the card also informs the patient how to obtain repeat prescriptions and gives the number of occasions that this can occur before an appointment with the doctor is required. Every request for a repeat prescription results in the doctor having placed in front of him a blank

prescription form, the special card, and the medical record of the patient. Details of the prescription are entered on the special card and also put in the medical record. The system may be evaluated by comparing the number of prescriptions issued with individual medical records will then show whether the policy is being implemented and whether there are any differences in the pattern of repeat prescribing between different doctors. Evaluation of this kind may lead to modification of the policy and may also lead to changes in the doctors' prescribing habits.

Hospital referrals

Most referrals made to hospital by general practitioners are for outpatient appointments rather than for emergency admissions, and of these referrals the most common are to ear, nose, and throat departments. Wide variations in criteria for ENT referral exist among practices and among doctors in the same practice. What are the reasons for this disparity? Could practice policy engender more effective and efficient use of hospital resources? It is clearly inefficient to refer children for tonsillectomy in large numbers to an otolaryngologist whose policy is to carry out tonsillectomies only in unusual cases. From discussions between this specialist and his GP colleagues there may emerge agreed policies. Clear criteria could be established that had to be fulfilled before referring a child for tonsillectomy. Similarly, it may be possible to obtain the views of the ophthalmologist about the appropriate management of a child with a squint: a clear policy in this area would avoid premature referral on the one hand and unnecessary delay on the other.

Many general practitioners can admit patients to hospital beds. Since the practice as a whole will be providing on-call cover for 24 hours for the patients in these beds a policy is necessary to identify the types of cases that might be considered suitable for such admissions and to define which of the doctors will be responsible for providing medical care in the ward.

Conclusion

In our training in clinical medicine we have become accustomed to the concept of curative medicine, which requires the skills of diagnosis and treatment. Much of general practice is in the sphere of caring and prevention rather than curing, and managerial qualities of accessibility, organisation, and effectiveness are essential. Practice policies should be seen as a tool in the development of such qualities. They are simply guidelines that should help to make medical care more rational and more efficient. Deviations from such guidelines are to be expected, and indeed the guidelines themselves must be under constant scrutiny and expected to change. As in politics ideal policies are impossible. They represent our best attempts to reconcile infinite patient needs with finite medical resources.

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