RESEARCH AND GENERAL PRACTICE

THE END-RESULTS OF TREATMENT

BY

C. E. S. FLEMMING, M.R.C.S.

On all sides we are being told that, in order to improve the country's medical services, medical research should be greatly increased and advanced. Subsidized by the Government, this would demand buildings, equipment, specially qualified investigators, all at a considerable cost. There is, however, possible another form of research, requiring none of these adjuncts, only approval, keenness, aptitude, and opportunity. It is an intensive inquiry into subjects which general practitioners have peculiar opportunities for investigating, and it could be undertaken by them in conjunction with their everyday practice. The work would not, of course, be in any way compulsory or a duty; just another facet in the many-sided outlook of a doctor's life, an outlook that has been casually used by most of them, but not methodically or persistently—the worrying out of problems that occur almost daily. It is a desire for a further and more complete knowledge about much that confronts the practitioner, which though latent in all his work has not been generally recognized as coming definitely within the ambit of his practice.

A form of research that must of necessity be observational is apt to be depreciated as not being truly scientific, yet it has in the past yielded results very valuable from the clinical point of view. As a study it must develop naturally and by degrees, fostered by a doctor's desire, with the encouragement, inspiration, and assistance of teachers, hospitals, laboratory workers, and others.

The Patient at Home

When a doctor starts practice he finds it difficult to recognize his patient as the same that he knew in the ward in charge of a nurse. He finds him and his family living under conditions he really knew little of—quite a new problem. He wonders whether the treatment he has seen succeed in the ward can be properly and successfully carried out in the patient's home. He begins to doubt, wants to know more of the condition that may influence his treatment, the chance of directions given in regard to rest, quiet, diet, and so on being properly carried out. He wants to know not only all the factors of the experiment which he considers every treatment to be, but also the result—the real tested result—of the experiment.

There must be many in like perplexity—men willing and with the aptitude to make inquiries and evaluate the results. For it is the family doctor more than any other who has the opportunity not only of seeing the very beginning of disease and what led to it but also of proving the real value, the end-result of treatment, and who, living as he does in close contact with his patients, is most likely to deplore the too-frequent failures of treatment and want to know the reason for this lack of success.

Need for Purposeful Search

We do not want mere collectors of information, but men with a purpose in their inquiry, to synthesize teaching and hospital practice with private practice and explain unexpected and unsatisfactory results of treatment—the impreciseness of such research may offend the sensibilities of the expert researcher, but to call it an "inquiry into" would be too reminiscent of a "Committee of Inquiry," which is the last thing wanted.

There must be, in the profession, many men of original mind thinking at times of the rightness of what they once doubted, now that they are free of the dominating influence of authority, wanting to prove it right or wrong, wondering whether their garden may not have grown too many useless plants for want of deeper digging when they could be thrown out, making room for something better, of more real value.

The younger men with unfaded aspirations and ideals will be the most likely to realize the need for more intensive inquiry as to the real value of their daily work, and among

these we may fairly look for original researchers. Their opportunities, if available, would be great—men with the mental capacity and aptitude who would, if they could, devote more time to so fascinating a study, but they have too often been prevented by the rush of work necessary to make a living. Some have, in spite of all, succeeded. Such a one was that great example Sir James Mackenzie, the general practitioner whose original clinical research was of value without measure. He is described by a biographer, Sir Thomas Lewis, as "an exact observer, with accurate deductions, a deep-rooted distrust of authoritative statement, originality of mind, determined in purpose, a real investigator"—a fine ideal for the humblest researcher.

Appraisal of Failures and Fashions

Among the many subjects not only suitable but asking for investigation by the family doctor one may well put the results of treatment, especially the failures, as they are not so freely proclaimed, and it is necessary to examine them because if any sort of treatment is found to be useless it should be discarded, for so long as it is available or made use of, it prevents search for the really effective. The warning of a wrong path may save trouble or even disaster. It is the family doctor who has the most likely opportunities of observing the effectiveness or ineffectiveness of treatment, and it is the ultimate results that we want to know, because what seems to be early success may yet end in failure. With a new carburettor in your car you are not satisfied with a trial run on the level road: you want to test it up hill and under all sorts of conditions, its effect on fuel consumption and speed.

Inquiry into the results of therapeutic agents requires much care, and detachment from empirical, unproved, but fashionable agents. Under "treatment" should be included the important but as yet undetermined position of psychotherapy in adults, a field clearly for the observation and criticism of the family doctor, who can probably best estimate its ultimate value in actual practice. Treatment by the surgeon we assume may be readily appraised, probably so generally; but here again fashion or custom, or plausible advocacy, has sometimes overstated the case and prejudiced some such practice as the fixing of movable kidneys, excising feet of colon, for conditions which would not now be thought to require it, and, in a somewhat different category, the numerous cases of gastrectomy and gastro-enterostomy. These and other questions of surgical treatment, some too recent to-day for fair criticism, might with advantage to all be the subject of general practitioner inquiry as to not only ultimate failure but later unwanted and unexpected after-effects, or even harm.

A Wide Field for Inquiry

This list of possible matters for inquiry as to their influence on the result of treatment is getting too long, so there can only be mentioned old age, heredity, economic and domestic and social conditions, housing, with all of which the general practitioner in particular is concerned, and the import of which, as affecting treatment, he has such a special opportunity of ascertaining. The doctor meditates on all these things, but has no time, if he has the incentive, to carry his meditations a stage further, though he probably compares the findings of actual practice with his textbooks, and attempts to draw conclusions as to the reality of "cause and effect."

These suggestions are merely tentative. Research to be of real use and effective will need to be more methodical. One can contemplate a doctor, when he has time, carrying in his pocket a small notebook, entitled "Clinical Research," in which he will note when he comes across a case of failed treatment: The case; the remedy, medical or surgical; how applied, under what conditions and surroundings; failure, immediate or remote; the reason; the lesson. For want of time this would be impossible under existing conditions of practice.

Although such research as here proposed must be individualistic, it would be better that it should be by groups of congenial workers, for there would have to be considerable numbers of separate observations, and the comparison of findings by the different members of a group would help to suggest errors and new points of observation. Eventually these might be not masses of records but collective opinions; and

other groups investigating the same subjects might, with the assistance of expert researchers, integrate their deductions as to causes and results, opinions, new outlooks, new ideas, and, better still if one could be found, the expert researcher might give advice as to the method of inquiry.

The suggested list of subjects for inquiry is merely intended as a reminding note to those who have been so long and are still striving so hard for success in treatment in spite of disheartening conditions, that still more striving will yet be demanded in their endeavour to find reality.

The Day's Work, and Beyond

If even this simple form of research is to be undertaken it can only be done if the doctor has time to do all his work deliberately; anything less than this means that whatever his duties, whatever his pay, whatever system he works under, the public will not, cannot, be receiving the best possible medical service. If the public realized how unsatisfactory some treatment is from the doctor's point of view they would not remain so complacent and satisfied with what they are getting as they now are.

A general increase of research into the results of practice might increase the quality but not the quantity of the general practitioner's work. Some diversion from routine is wanted to help him to look beyond the day's work, which has been carried on under such serious difficulties, with little encouragement, often disillusion and disappointment. He wants something to encourage and help him to think originally, independent of fads and fashions, of patients and employers, some release from drudgery. Temporary relief comes to some by outside hobbies, but something within the sphere of his profession may add zest to his everyday round—may give a wider interest within his work for the better enjoyment of his professional life and for the benefit of his patients and of medicine.

The outcome of this should be of some interest or even value to specialists and consultants as well as other practitioners. It is a long view of what might be done, an idea that it is hoped others much more fitted may approve and help to develop.

SMOKE CONTROL IN GREATER LONDON

Representatives of 67 boroughs and other municipal authorities, members of the Greater London Advisory Council for Smoke Abatement, met at the House of Commons on May 8 to consider the reduction of smoke in post-war London.

The conference was opened by the Minister of Health, who said that great areas of London would not look as they do if it were not for the smoke of the past and the present. He reminded the conference that the Government had not been inactive. Between 1919 and 1923 there was an improvement of about 50% in the deposits dropped on London. Then there was a stationary period and some deterioration, but between 1935 and 1939 there was again an improvement. He was very glad to find this revival of activity on the part of both that organization and the National Smoke Abatement Society and the realization of the fact that this was now the time to move. He hoped that their campaigns of education would be successful. He would be glad to do what he could in the field of research and in collaboration with the Ministry of Works and the right sort of standardization. In regard to post-war housing they had to face a limited supply of naturally smokeless fuels and a relatively small supply of carbonized fuel. There were also considerable difficulties now in regard to the better cleaning of coal. The direction in which one hoped for progress was in the manufacture of a really satisfactory improved grate which would burn raw coal more completely and would also burn smokeless fuels satisfactorily. There was no escaping the fact that the British public liked an open fire, and what they had to achieve was a fire which would be equally attractive, was economic, and would not need continuous watching. From all the expert opinion he could get it would not seem that research in this direction had yet reached finality. The departments concerned were very interested in the matter, and there was every reason why they should be because the loss of all kinds due to smoke was very great indeed. The building in which they were meeting had suffered terribly from atmospheric pollution.

The Minister continued that his Ministry, together with the Ministry of Works and the Ministry of Fuel and Power, were agreed that there should be efficient domestic heating appliances and practical methods of smoke prevention. During the summer the Ministry of Works would issue a housing manual in which the latest available knowledge on the subject would be given. He was anxious to do all he could to avoid smoke in the new suburbs and prevent the continuous spoiling of the centre of our cities.

SCOTTISH SCIENTIFIC ADVISORY COMMITTEE

The terms of reference of the Scottish Scientific Advisory Committee have been revised and are now as follows: "To advise the Secretary of State on the application of the results of scientific research to public health administration and to promote medical investigations designed to assist the Secretary of State in the discharge of his responsibilities for the health services in Scotland."

Membership of the committee has been widened in the interests of medicine generally and includes: Sir John Orr (chairman), Prof. D. Cappel, Prof. F. A. E. Crew, Prof. E. W. H. Cruickshank, Prof. D. K. Henderson, Prof. J. Hendry, Sir A. S. M. Macgregor, Prof. T. J. Mackie, Prof. J. W. McNee, Prof. C. McNeil, and Prof. Noah Morris. Dr. I. N. Sutherland of the Department of Health for Scotland is medical secretary. Normally the appointment will be for four years, but to provide for rotation five of the members now appointed will retire after two years. The chairman of the Medical Advisory Committee (Sir John Fraser) and the secretary of the M.R.C. (Sir Edward Mellanby) are *ex-officio* members of the committee but are not subject to the rules of retirement.

One of the new committee's first tasks will be an investigation into the causes of infant deaths from infections. In making this announcement Mr. Tom Johnston recalled that the reports of the original committee, which was due to retire in 1940 but was kept in being because of the war, on the Emergency Bacteriology Service and the Blood Transfusion Service paved the way for setting up services that had worked smoothly and efficiently. The results of an investigation into the health and working experience of 1,000 Scottish men and women who had been boarded out of the Forces were incorporated in the Department of Health's booklet *Experiments in Social Medicine*, while an earlier report on maternal mortality (in 1935) formed the basis of the Scottish Maternity Services Act, 1937. It was likely, he said, that the subject of mental deficiency might be referred to the committee for inquiry and investigation later.

Medico-Legal

A PENSION FOR TUBERCULOSIS

Originally workmen's compensation was intended to be payable only when a workman suffered injury or death by accident, but quite early in the history of the Acts the House of Lords held¹ that anthrax was an accident causing injury. Lord Halsbury, Lord Chancellor, said: "When some affection of our physical frame is in any way induced by an accident, we must be on our guard that we are not misled by medical phrases to alter the proper application of the phrase 'accident causing injury,' because the injury inflicted by accident sets up a condition of things which medical men describe as disease." The same principle was recently applied in construing another Act.

A policeman was discharged from the City of London Police Force for pulmonary tuberculosis, and applied for a special pension for life under the Police Pensions Act, 1921. This provides that every member of a police force incapacitated by infirmity of mind or body occasioned by an injury received in the execution of his duty without his own default shall be entitled to a pension. The police authority, the Common Council, would not allow him a pension, but quarter sessions overruled it. The Council appealed to the Divisional Court, submitting that tuberculosis was not an injury under the Act, and that there was no evidence that the policeman had contracted it in the execution of his duty. The court² unanimously found in his favour, and Mr. Justice Humphreys said he was not aware of any legal principle or canon of construction which should prevent tuberculosis from being described as an injury occasioning infirmity of body. When the courts disallow claims of this kind for workmen's compensation, the reason is not the absence of proved injury but the failure to identify any event which could, however loosely, be called an accident. Under the Police Pensions Act there is no need to prove an accident; the injury is sufficient, and the court were quite clear that the tuberculosis was an injury. On the question of fact, the learned judge admitted it would probably be impossible to establish by evidence the day, week, or even month during which the infection of the lung occurred. The court, however, was not required to decide the issue of fact, but merely to be satisfied that quarter sessions had had some evidence on which they could conclude that the injury had occurred in the execution of the man's

¹ Brintons v. Turvey, 1905. A.C. 230.

² Garvin v. Police Authority for the City of London, (1944) 1 All E.R. 378.