SOCIAL AND COMMERCIAL PRESSURES ON THE GP AS REGARDS THE USE OF DRUGS

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A mere 12,000 years ago man was still living in the stone age, and with minor modifications, he was living much as his ancestors had lived for the previous two million years. Twelve thousand years ago as the last ice age receded, the winds of change began to blow, and man's evolution from the life of a hunter-gatherer started. It was a slow process at first, over many centuries, and then with increasing momentum, his progress, if we can call it progress, to the modern city dweller accelerated until over the past 150 years it has reached the proportions of an exponential curve. These rapid changes have altered quite considerably some of man's basic behaviour so that in the life span of many folk alive today, astonishing modifications have taken place in man's attitude to pain and illness.

Let me give you an example of what I mean. During the war I was for a time staff officer to an ADMS. My boss was a tough old Boer war veteran and we were inspecting a dental unit. The DO was busy giving a local anaesthetic to an African soldier before an extraction. The ADMS seemed worried and a bit disgusted, and it was obvious that he did not approve of the local anaesthetic, and furthermore he seemed to imply that my generation was too soft for words. When I suggested that if he had to have a tooth out, he would want some form of anaesthesia, he disagreed. 'I had a complete dental clearance in 1902 without any anaesthetic,' he told me. Impressed but a trifle incredulous, I asked him if it wasn't rather painful. 'It was sheer hell,' he replied. 'In fact I had to have half out in the morning and the rest out in the afternoon.' How many people today could contemplate such an ordeal?

It is 40 years since I qualified, and I am sure that both doctors and their patients had a different attitude to illness. Tuberculosis was rife, and there were always a few young people who were clearly dying of this disease. Indeed chronic illness in the younger age groups was accepted as a part and parcel of life. Lobar pneumonia was common, and once diagnosed, one knew that it would be 5 to 7 days before there was a crisis. Both the family and the physician were conditioned to wait in an agony of suspense for the outcome. Patients were visited four or even six times a day. The doctor was powerless to help in a therapeutic way, but his interest was a tremendous morale booster for both the patient and the family. The time spent on

the case, and the sense of empathy were more effective than any drug then available.

Today the modern physician with some two to three thousand drugs available to him, is therapeutically far more potent, and what is more his patients expect to get better quickly. They almost demand a 24-hour cure. If the illness is a streptococcal throat or a boil, this usually happens, but if it is glandular fever or shingles the illness can last for a week or longer, and then the family is likely to become anxious, despondent or even offensively aggressive. 'My throat should be better by now,' is their attitude.

There is a great reluctance to accept that any disability is incurable. A woman with multiple sclerosis is chairbound, but she has not deteriorated much in the past 20 years. She still demands a cure. From time to time I try to explain to her in simple terms what is wrong and that sometimes disabilities have to be accepted. As the old saying goes, what cannot be cured must be endured. If a diabetic goes blind because of disease at the back of her eyes, no one can remedy the situation. After about ten minutes of this kind of talk, she smiles sweetly and says, 'But it would be nice if you could find a cure for me'. In general the pressure is on the family doctor to produce a quick cure, and with his vast resources, there is a conviction in the mind of the patient that if only the GP tried hard enough he could produce a panacea for everything.

In all fairness I do not think that this sense of urgency applies nearly so much to the psychiatric patient. It is rather the reverse, the sick person and his relatives are often pleasantly surprised when help is forthcoming in this sphere. Nevertheless some people expect assistance to meet all the minor trials and tribulations of life. Anxious parents bring their children along because they feel help should be forthcoming to soften the trauma of starting at a new school, or before some examination. Driving test candidates often ask for a tranquillizer. Today we are very much a nation of pilltakers. Peregrine Worsthorpe suggested that once upon a time only the very sick put themselves at risk by taking drugs, whereas today only the very healthy can do without them.

The pressure is on the GP from a second angle. It is just about impossible to keep pace with modern

pharmacology. Every drug has two names, the chemical term is often unpronounceable, and the doses are hard to memorize. Being one of the surviving generalists, the GP has to know a bit about everything. It may be details about the electrolyte imbalance of heart failure, or the upset blood chemistry of infantile diarrhoea as well as the effective levels of blood lithium. With the ever increasing fragmentation of medicine into specialties, the academic journals get more numerous, and ever more indigestible. Over and above this we are inundated with free papers and glossy magazines from the drug firms, and there are just not enough hours in the day to read everything. These regular issues from the pharmaceutical industry are reinforced by visits from persuasive representatives. Some of them can be most useful and a few are old friends. We do need information about new drugs, and one must admit that it is the drug firms that are doing most of the research.

However, I want to know from the representatives more about the drugs with which I am familiar, I do not want to be sold new products. It is far safer and more appropriate that we should learn about new drugs through medical rather than through pharmaceutical sources. It is unfortunate that sometimes our patients learn of the latest wonder drug from those encyclopaedias of medicine, the *News of the World*, and the *Readers Digest*. It seems a pity that the public should have false hopes raised, and that we family doctors should be harassed by the newspaper cuttings we so often find on our desks. These extracts extol the virtues of a drug which may still be on trial, and not even available to us in general practice.

There is a third area of pressure on the GP in connection with modern drugs. These are often dangerous in the wrong hands or in the wrong dose; they are potentially far more toxic than the bottles of coloured water we used to dispense in the 1930s. In the annual report of the Belfast Poisons Information Service, Professor Elmes pointed out that 65% of all enquiries were about drugs acting on the CNS. The list included hypnotics, tranquillizers, and the anti-depressant drugs. He concluded that such figures reinforced the view that patients with depression could not safely be treated at home with this type of drug.

These are strong words, and many GPs, myself included, would be very reluctant to give up domiciliary treatment of depression. We must be grateful to Professor Elmes for reminding us once again that these drugs can be dangerous, and the handling of the depressed patient requires considerable sympathy and skill. However, if such patients are adequately assessed, and given the supportive treatment which is always necessary, then I feel that the drug treatment of depression is well within the scope of general practice for about 90% of the cases which come our way.

These are the kinds of pressure that are on us in

general practice. However, on the credit side, are factors which keep us from being overwhelmed. The first is postgraduate education. This has evolved and improved immensely over the past 20 years. Postgraduate courses today are usually well prepared and most useful; indeed today they are accepted as being an essential part of general practice. Now that the GP has found a foothold in the academic world, GPs themselves are getting more involved in teaching. This is important, because while we are grateful to the specialists who bring us up to date in their subjects, there are certain facets of our work we can only learn from fellow GPs.

The second helpful factor is our tendency to work in groups. There is little doubt that the single-handed GP gave the most satisfying personal service to his patients, and this was in fact the best form of general practice from many angles. There were however two snags. The isolation was bad, and the case load was too small. In a group we rub shoulders with colleagues and problems can be discussed over a cup of tea or indeed at any time. With a list of say 3,000 patients, I may not see a case of subarachnoid haemorrhage for years, but with a combined list of 9,000 if one of my partners tells me of a case he had in the night, my attention is drawn to this clinical problem. One needs to be reminded of such rarities.

In some ways the surgeon, it might be argued, is the most responsible of doctors. His, surely, is the most dramatic form of medicine. Sometimes he actually effects a cure, whereas most of us only encourage recovery, or advise on maintenance therapy. Once he has decided on his course of action, he has to wait a while before he carries out such measures. He has time to think, and when he does act he is kept on his toes because his form of therapy is always in front of witnesses.

The position of the GP could hardly be more different, and in some ways his work is even more demanding. He has to make up his mind on the spot. We have seen how he is under pressure to obtain a quick result and he can well be bewildered by a plethora of drugs. Before him lies his prescription pad, pleading to be used, and there is no one looking over his shoulder. It is so much easier to write out an EC 10 for a tranquillizer than to listen to the patient's problem.

The tremendous moral support which we had to use 40 years ago is still urgently needed in the stressful world in which we live; this powerful nontoxic tranquillizer is there for the asking. It is still as useful as ever it was. Happily more and more family doctors are making use of it. With improved undergraduate training, the modern family doctor is far better equipped than I was when I qualified. It is finding the correct proportions of drug and interest in the patient which are so important. Speaking of a local consultant, a patient told me that when she talked to

him, she felt that she was the only patient he had. This is surely medicine at its best.

Way back in the 1930s we had a few useful drugs like morphia, ephedrine and digitalis, but these had to be well laced with plenty of undivided attention to the

patient. The combination of drugs with clinical skill and humanity is the best prescription of all, and with a happy blend of compassion with modern drugs, our motto might well be, 'the mixture as before'.