# Editorial

## To write prescriptions is easy, but to come to an understanding with people is hard

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The quote is from Kafka's[1] intriguing tale *A Country Doctor*, which is about a night visit to a young patient. His horse has died, but a strange unearthly groom turns up and offers a pair of enormous horses which transport the doctor instantaneously to the bedside. Too late he discovers that the exchange is at the expense of his maidservant Rose. He makes the diagnosis – a worm-filled wound in the right iliac fossa – but has no treatment and is humiliated by the family and the villagers, who strip off his clothes and lay him on the bed beside the patient.

Eventually he escapes but is doomed to ending his return trip naked on the back of one of the now very slow horses, with his clothes in a bundle and his furcoat caught at the back of the gig. According to Felice Aull and Jack Coulehan, 'the story symbolizes the experience of being a healer at any time or place. The sick are needy, vulnerable and sometimes demanding; the physician is only human, can only accomplish so much and is often mistaken.'[2]

*Prescribing as it was: An envelope which once contained cocaine, prescribed by Carl Koller, an associate of Sigmund Freud, circa 1883. The prescription is written on the outside of the envelope. Photo courtesy Library of Congress.*

The first home visit I ever did in general practice in 1968 was to a lady who had just fallen down the stairs in her house and twisted her ankle. I arrived with my shiny new case, made the appropriate diagnosis and was soon applying a crepe bandage to the accompaniment of a commentary to her husband on the skills of the new doctor. 'Look at how neatly he does it, John. Doctors are not usually so good at doing that sort of thing. Oh that's much better, Doctor.'

They say that flattery gets you everywhere and soon I was eating out of her hand. Seven years of medical education had not prepared me for this. 'While you're here, Doctor, I wonder if you would be so kind as to give me a prescription for a few of the sleeping capsules that Dr Mackay always gives me. It would save John the trouble of going down to the surgery for them.' It was an offer I could not refuse and so the new prescription pad came out and was inscribed with *Caps Tuinal 200mg /Sig 2 nocte / mitte 30 days supply*. I arrived back at base full of the pride of a job well done, only to be met by the senior partner who said that he had omitted to tell me that she was a barbiturate addict and hoped that I had not prescribed for her. It was a first lesson that the sick are needy, vulnerable and sometimes demanding; the physician is only human, can only accomplish so much and is often mistaken.

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Over the ensuing 33 years , I have always been struck by how easy the task of prescribing seems when you take the human dimension out of the equation. There are many who see the work of general practice as simply a question of making the right diagnosis and issuing the correct treatment, but they are usually academics, administrators or politicians.

In the personal care of patients there is this different and additional difficulty which can be observed only after you have been inducted into being 'the doctor'. In the three practices to which I have fulfilled this role, people have arrived in the first days and weeks to test whether 'my pills' can help their acute symptoms and to collect prescriptions for 'their' pills, which have been issued to them since time immemorial and have become part of their physiology.

In Kafka's story the patient and his family were pleased when the doc-

tor made the diagnosis by noticing the wound but the doctor still had to run from the taunts of the community when he could not give a positive answer to the question 'Will you save me?' The doctor expresses frustration which is very like the things you hear from modern general practitioners. 'That is what people are like in my district. Always expecting the impossible from the doctor. They have lost their ancient beliefs; the parson sits at home and unravels his vestments, one after another; but the doctor is supposed to be omnipotent...' The induction process – and I have observed it in Kirkintilloch, Dundee, Dunedin, Al Ain, Ipoh and Winton – involves taking on this mantle of omnipotence and prescribing is a major ritual in the process.

### Acute prescribing – the doctors' pills

People still expect the impossible from the doctor and prescribing has to be viewed within the necessary constraints of the current business environment of New Zealand general practice which means that, in order to survive, most of us have to see 30–40 people a day. Many of the people I see acutely have the expectation that I will explain and lose their symptoms – a tall order indeed – but I persist with this conjuring trick. The vast majority have respiratory illness, trauma, symptoms such as pain, dizziness, diarrhoea or dysuria, or skin problems, and they expect me to prescribe. I doubt if many of them would come if I did not prescribe, not just because of the therapeutic power of the drugs I prescribe but also because of the symbolic power of the prescription within the patient-doctor relationship.

Many of the techniques which we practise in acute medicine are relics of the 'apothecary system', although in our desire to become academically and professionally respectable we are in danger of handing this business to the pharmacist and the healthfood shopowners. We stand at the counter of our sick shop[3] and match the patients' symptoms to bottles on the shelves behind us.

We don't talk much about this 'corner dairy' aspect of what we do, but the transaction has some major advantages to doctor and patient, particularly if the doctor is aware of the opportunities afforded by these episodes and their possible pitfalls.

The major advantage to the patient is the fact that they can continue living their lives while the doctor tries to sort things. Prescribing provides what I call 'the hourglass effect' by which a time space is created during which people can improve. This also is combined with the placebo effect where even inert substances can lead to the healing of the patient if they are sold with enough conviction.

However the main opportunity is the development of a confidence within which healing can occur and in my experience the healing opportunities arise almost accidentally as we go about the ordinary tasks of diagnosing and prescribing. The pitfalls exist because we always underestimate the power of the drug doctor and of the active drugs at our disposal, many of which we use as placebo.

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As I pointed out some years ago[4] antibiotics are the placebo we prescribe most often and this is reflected in the article in this issue by Hall and Martin. Still the most difficult thing to do is to explain that it is likely to be a viral infection and that antibiotics will be of no value.

Hart claims that 'the doctor's sick shop, relying on episodic presentation of symptomatic illness, is inadequate for conservation of community health or the effective application of medical science', but I am not so sure. Acute illness is still a powerful driver of help-seeking behaviour and the escalating costs of medical care are often the result of a generation of doctors who are so worried about being wrong that they order more and more tests and refer more to specialists.

What we need is not a change of the setting but awareness in the doctor and a resolve to do the best we can in the circumstances and avoid the worst pitfalls. To wash our hands and insist on evidence-based treatment or nothing is to risk obsolescence because, as Hart himself points out,[5] the advocates of evidence-based medicine 'accept uncritically a desocialised definition of science, assume that major clinical decisions are taken at the level of secondary specialist rather than primary generalist care, and ignore the multiple nature of most clinical problems, as well as the complexity of social problems within which clinical problems arise and have to be solved.'

### Long term prescribing – the patients' pills

While we often stress the role of noncompliance, most of the drugs that we start prescribing are continued long after they are needed. Around us at the consultation sit the ghosts of doctors past and we younger doctors suffer by comparison.

A study done long ago[6] demonstrated that long term prescribing increases with the age of the patient and that there are certain drug groups

which once started cannot be stopped without great difficulty. The vast majority of this prescribing is in the treatment of chronic illnesses such as hypertension, ischaemic heart disease and heart failure, but many drugs are continued long past their usefulness and they are also used to treat unhappiness, loneliness and panic.

As Peter Parkinson says in this issue, 'simply calling a feeling an illness does not really solve anything. The robber of health and good feeling (anxiety and panic) multiplies, the potentially lethal drugs for killing the feeling proliferate and dependency on these drugs becomes a risk and a reality. It does keep the consultation brief and may reduce risk. But this is clearly incomplete, so let's try another paradigm.'

The classic description of the repeat prescription by Balint et al[7] was published under the title 'Treatment or Diagnosis?' The understanding given by these early studies was that the repeat prescription was a treaty drawn up between patients and doctors not to bother each other unduly. There are many of our patients who live lives of quiet desperation and I have known those over the years who have asked for what is fashionable through Tuinal, Mandrax, Mogadon, Temazepam and Zopiclone.

Some of us make ourselves feel better by prescribing antidepressants at night. For those who believe that this does not happen now, the study by Pullon et al in this issue shows that 25% of respondents would sometimes provide repeat prescriptions for anxiolytics without seeing the patient and 5% would provide these frequently. In my Dundee study, almost 20% of females aged 65–74 were on long term tranquillisers and 20% were on long-term hypnotics. In the words of the Balint study these prescriptions are 'written in steel and in concrete and are not easily dismantled or remodelled.' We are always asked just for a few more and it always seems easier to comply than to be a policeman or to try another paradigm.

## Emphasising the role of healing

The therapeutic ending to Kafka's tale came when the doctor was stripped of his clothes, laid on the bed beside the patient, and the two had a very confidential chat. The patient confessed his lack of confidence in the doctor, 'I have very little confidence in you. Why you were only blown here, you didn't come on your own feet. Instead of helping me, you're cramping me on my death bed. What I'd like to do is to scratch your eyes out.' The doctor responds with 'Right, it is a shame. And yet I am a doctor. What am I to do? Believe me, it is not too easy for me either.'

Earlier the children of the village sang these words to an utterly simple tune: *Strip his clothes off, then he'll heal us, If he doesn't, kill him dead! Only a saw-bones, only a saw-bones*.

Modern medicine seems to be reducing us all to 'saw-bones' – only good when we can do one or perhaps two things well. But people out there want to be healed, and they cannot understand why doctors cannot fulfil this ancient role. In their timely discussion, Dixon et al[8] make the point that patients are looking for physician healers while GPs want to be expert practitioners of modern medicine. The top priorities of patients in primary care is not for newer and more expensive drugs but for doctors who listen and explain clearly, who allow sufficient time for consultation and with whom they are able to get an appointment. Prescribing is only one of the competencies in the armoury of the physician healer, but if it is to be successful in healing it has to be accompanied by communication.

If we were to talk more with mothers about their anxiety during acute childhood illness, perhaps we would prescribe fewer and less potent antibiotics. If we were to individualise evidence by using acute prescribing in N of 1 trials[9] so that therapy was only given to known responders, that might be a start. A recent study[10] has begun to explore ways of seeking concordance with those who are on long term therapy but do not use the treatment as prescribed.

This is not a story with an answer or a happy ending. The doctor returns to his home in despair. As we said, the sick are needy, vulnerable, and sometimes demanding; the physician is only human, can only accomplish so much, and is often mistaken.

General practice is the most difficult area of medicine precisely because it involves dealing with people. Prescribing, while far from easy, cannot be made perfect, but perhaps we could try to make things just a little better by thinking and talking before we write.

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