PRACTICE OBSERVED

Interesting GPs of the Past

Dr Thomas Kirkland of Ashby-de-la-Zouch: 1721-98

R T AUSTIN

The Gentleman's Magazine of 1760 describes the fatal shooting by the deranged Laurence Shirley, Earl Ferrers, of his steward and the part that Thomas Kirkland played in soothing the earl and extracting the ball from the steward. After the earl was hanged at Tyburn Kirkland kept the rope and also the ball.

Kirkland, a surgeon and physician, was born at Ashbourne in 1721, the son of a solicitor. He was apprenticed to a Loughborough surgeon and studied in the London hospitals before settling into practice at Ashby-de-la-Zouch. He later qualified as a physician by obtaining the MD of St Andrews University in 1774. At this time, the Surgeons Company, under the influence of Cheselden, had become divorced from the Barbers Company, but the strict professional division between surgeons and physicians was great. Kirkland, having experienced the artificial demarcation, spent much time reasoning for its abolition, anticipating the Medical Act of 1858, which unified the profession in terms of requirements for training. The medical profession knew Kirkland as a writer, and it is to his medical writings that his entry in the *Dictionary of National Biography* chiefly refers and which provide an insight into the man and the theories and practice of his time.

A writer of depth

Kirkland's daily professional life was busy and his services were often in demand in the surrounding towns. Allowing for the pressure of work, his writings were notable for the variety of the subjects and the depth in which they were considered. His clinical descriptions were lucid, accurate, and usually diagnostic. The management that he describes reveals him as being self confident and optimistic:

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A man between 20 and 30 years of age, being near the lime-kiln at Ticknall, was knocked down with lime stone, from a blast, and one of the parietal bones was so violently broken that when all the loose pieces were removed an opening was made into the cranium more than 7 inches in circumference. The quantity of the cineritious part of the brain taken up from the ground at the time of the accident filled a large pill box, which the people had at the house, and a rough stone more than half an ounce weight, which had penetrated the substance, was removed at the first dressing.

The man being unexpectedly alive, I went next morning with my son to see him, and had I not have known that lacerated wounds of the substance described would, under particular circumstances, heal like wounds in other parts of the body, I should have given up all hope of recovery, so dreadful was the aspect; a bare possibility of success encouraged us to pursue proper treatment. We removed all the lacerated brain which lay in the wound, and upon minute enquiry discovered a still larger piece of stone forced lower down, which was extracted by a pair of forceps. Much more of the cineritious substance was discharged in the matter the ulcer afforded at each dressing for some time, but at last the ulcer became clean, and healed, leaving a hemiplegia on the contrary side to that on which the accident happened. Insensibility, stupor, and sleepiness immediately followed the accident, but gradually went off in a few days without one true apoplectic happening; whereas if instead of being extravasated and discharged, the fluids had been obstructed and accumulated within the vessels belonging to the brain, a coma and death would probably have been the consequence.

On the lethal effect of raised intercranial pressure arising from a closed head injury:

A keeper in the forest of Needwood was set upon by some deer stealers, who beat him violently on the head with their weapons; and he instantly became insensible, and hemiplegia seized his right side; he was delirious and slept without either snoring or sonorous respiration. Several days passed before I saw him, and as no surgical treatment had been pursued, I laid the skull bare but neither fracture nor fissure could be found. Suspecting the contents of the cranium to be injured, a trephine was applied on each side of the sagittal suture; the dura mater was found black from blood stagnating in its vessels and fibres and distended by fluid underneath. Upon dividing this membrane with a lancet a considerable quantity of coagulated blood and bloody serum was discharged; nor did this kind of evacuation cease over a week or ten days, but at last gradually decreased, the patient got perfectly well, and was able to shoot his deer as usual, which I think would not have happened if pressure from extravasating blood had been capable of

producing an apoplexy. In the present instance I look upon the insensibility and hemiplegia to be owing to concussion, because they immediately took place, and the discharge from the opening probably unloaded the vessels, etc, and prevented putrefaction of the membranes and brains. Indeed I have opened the heads of several who died of fractured skull, in which the veins were turgid, and more or less coagulated blood was found; and yet I do not remember having seen one of them die of the apoplectic symptoms described.

On an industrial disease:

We have in this neighbourhood pot kilns in which much lead is used. The workmen who powder the scoria of this mineral are subject to the bellon and to paralysis of the limbs from swallowing the dust that arises in this operation till it is almost impossible to conceive the quantity of lymph, which it secreted into, and became ropy in the stomach etc, and being coloured by the lead, is called by these artificers, sludge. I have several times seen both the colic and the paralysis cured by repeated vomiting and smart purchase; for a stronger purchase is required in this instance than in any I know of.

On serious bacterial infections:

But the most dangerous of all abscesses that belong to the abdomen is the lumbar abscess, that forms in the ciliary membrane about the psoas muscle, and points in the thigh, groin, back, or sometimes at the anus. Of these patients few I believe recover, nor indeed is it to be expected; as the source of the disease can seldom delay it drying, and the caries of the backbone is sometimes added to the melody. Some, however, I have seen survive these collections of matter, either tumour being suffered to break of itself and it's contents to drain gently off through a very small aperture, which prevents the free ingress of air, and violent spasms; for when a large tumour of this sort forms on the inside of the thigh, and breaks in a large opening in such a manner that the air has ready passage, we frequently see a violent colliquative fever succeed, but closes the scene in a very short time . . . the greatest hope of recovery is when the matter is mild and good, owing to it perhaps being a common purulent abscess; whereas when it is seropurulent, it seems to indicate a scrofulous origin.

Notwithstanding Kirkland's mistaken view on the origin of the infection the summary that he produced is remarkably sound. Roughly 10 years before, the surgeon Charles White (1728-1813) of Manchester had removed, by sawing, part of the upper shaft of the humerus of a 16 year old boy with scrofula, and subsequently a further section of the shaft sloughed off spontaneously. Kirkland was familiar with this type of problem:

The shoulder is seldom affected with abscess of the joint, compared with their frequency in the hip; yet there are not wanting instances of abscesses in this part, either from foul bone, or diseased ligaments; and of the head of the bone, either reseparating spontaneously, or being removed by operation. There is now in the neighbourhood of Burton-on-Trent a man from whom the head of this bone and several injuries adjoining to it, came away by itself, when a boy. He was also cured by a common apothecary; the man has a useful arm, and the cicatrix shows the greatness and extent of the disease.

Kirkland had removed bone in cases of fracture:

The lower end of the radius and ulna, and the upper and lower end of the tibia and fibula, have been removed by myself and others, in compound dislocation, with very little defect in the motion of the joint.

Richard Wiseman, surgeon to Charles II, first distinguished tuberculous disease of the joints as a "white swelling" of the joints. Kirkland had his own views on the morbid anatomy of the disorder:

From dissections in these instances, it appears that the ligaments become much more swollen, thickened, and even pulpy. The cellular membrane is loaded with a viscid glairy lymph. Abscesses are formed in the neighbourhood of the joint and the joint itself is often full of seropurulent matter. The cartilages are eroded, and the ends of the bone carious. In the beginning, provided the disease is local, it comes on slowly without pain, and the parts within the capsular ligament are unaffected; the patient undergoes no great inconvenience, except from being incapable of using the limb. In length of time the joint becomes contracted, in consequence of the weakness of the extensor muscles, and the ascendancy of those who bend the limb.

Concern with obstetrics

Kirkland also wrote on obstetrics. Thus to Charles White of Manchester, a pioneer of antiseptic midwifery:

I must confess, Sir, I cannot approve of the modern doctoring, which asserts that the puerperal fever is a disease sui generis, and that it always arises from the same cause; this opinion I apprehend is liable to many objections and may be productive in consequence, which we shall hereafter have occasion to mention.

I saw another woman lately, where part of the afterbirth had been brought away by force, and the part left behind; but from the account given me it does not appear that her attendant, or those about her, were apprehensive of anything being amiss till four or five days after when they were disappointed in the coming of her milk; though a quick pulse and fever were discovered, yet she was able to get up and notice her child, danger was not thought of till nearly a week after, when my assistance was desired. I found her dying, with flaccid breasts, a sore tender belly after having been troubled by what they called after pain; and all the symptoms, except a looseness, which usually attended puerperal fevers.

And on the technical management of delivery:

The immediate extraction of the placenta, a practice in fashion when I was a pupil to Dr Smellie: I think I have seen again fatally, even in the hands of those, who frequently perform this operation . . . I was called to give my assistance in bringing away the afterbirth; but upon arrival, I found the woman dead and the uterus inverted, and I believe without any violence being used . . . I was desired to examine the vagina, where so firmly united, that it was impossible to separate them without the utmost deliberation, without lacerating the placenta, leaving part of it still joined to the womb.

Thomas Kirkland was one of the most prominent citizens of the Ashby of his day. He was succeeded in the practice by Thomas John Kirkland, who was, in turn, succeeded by his son.

References

1 Anonymous. *The Gentleman's Magazine* 1760;30:230-6.
2 Kirkland T. *An enquiry into the present state of medical surgery.* Vol 1. London: J Dodsley and W Dawson, 1783:41-50.
3 Lee S, ed. *Dictionary of national biography.* Vol 31. London: Smith Elder, 1892:219.
4 Kirkland T. *A commentary on apoplectic and paralytic affection and on diseases connected with the subject.* London: W Dawson, 1792.
5 Kirkland T. *An enquiry into the present state of medical surgery.* Vol 2. London: J Dodsley and W Dawson, 1783:199-201.
6 White C. An account of a case in which the upper head of the os humeri was sawed off, a large portion of the bone afterwards exfoliated, and yet the entire motion of the limb was preserved. *Philosophical Transactions of the Royal Society* 1769;59:39-45.
7 Kirkland T. *A treatise on childbed fevers and on the methods of preventing them.* London: R Baldwin, 1774.

Accepted 3 July 1986

100 YEARS AGO

It is stated by the Indian papers that the Government of India has decided that considerable reductions in the expenditure of the Medical Departments of the three presidencies can, and ought to, be effected. The government admits that the large increase of British troops in India forbids any lessening of the number of the officers of the Medical Departments, but consider that the general establishment of station hospitals will, at any rate, obviate any need for an increase thereof. These hospitals are to be thoroughly scrutinised, to ascertain whether reduction of expense cannot be effected therein without loss of efficiency, and to see that no further disbursements are caused by the increase of British troops. To this end, medical officers are asked to economise in every possible way. Care is also enjoined that no unnecessary expenditure be caused by undue accumulations of stores. The surgeons-general have been called upon to state their opinion as to the economies that may, in their opinion, safely be effected. Their reports are to be forwarded to the several local governments, through the Controller of Military Accounts. The cutting down of hospital expenditure may have some temporary effect in saving small sums of money, but it is likely, in the end, to prove a very costly policy. We believe that the money value of each trained European soldier in India is estimated at a thousand pounds. It is well known that not only is invaliding to Europe most destructive of efficiency, but the actual cost of transmission of each soldier in an army-transport is equivalent to the cost of a first-class passage in the Peninsular and Oriental steamers. The health and life of the European soldier have, therefore, a very high money value, and to economise in the apparatus for maintaining the soldier in health and cutting short illness is a very sorry and short sighted mode of saving. (*British Medical Journal* 1886;ii:1119.)

Benefits

Informing patients about attendance and mobility allowances

JUDITH BUCKLE

Attendance and mobility allowances are important disability benefits that are designed to cover some of the extra expenses incurred by a disabled person. They are both tax free, non-means tested benefits and are not dependent on national insurance contributions.

Attendance allowance was introduced in 1971 for adults and children aged 2 years or over, with no upper age limit. To qualify for attendance allowance a disabled person must be so severely physically or mentally disabled that he or she has needed either frequent attention in connection with bodily functions—for example, going to the toilet, washing, dressing, or eating—or continual supervision to avoid substantial danger to self or others and has needed this help or supervision for six months. This benefit is paid at two rates: (*i*) the day or night rate (lower rate) and (*ii*) the day and night rate (higher rate). Attendance allowance is paid to the disabled person or to the person's parent and should not be confused with invalid care allowance, which is payable to carers of disabled people.

Mobility allowance was introduced in 1976 and may be awarded along with attendance allowance. To claim for the first time a disabled person has to be aged 5 years or over and under 66; once awarded it can be paid until age 75. To qualify for mobility allowance a disabled person must be unable to walk or virtually unable to walk or the exertion required to walk would be a danger to life or likely to lead to a serious deterioration in health. To qualify for mobility allowance the disabled person does not have to meet a six month qualifying period as for attendance allowance, but instead the medical condition must be likely to exist for at least a year.

Mobility allowance is designed to help disabled people become more mobile but may be used in any way the disabled person chooses. It is often used for buying, hiring, or running a car; hiring taxis; buying a wheelchair; and paying for holidays or days out. The purpose of attendance allowance is less clear, although "the original intention in introducing it was simply to direct some extra financial help to very severely disabled people." It may be used exactly as the beneficiary chooses—to pay for care, extra heating, special diets, clothing, and holidays, or indeed it may be spent on anything that the disabled person wishes.

Some are missing out

Since 28 July 1986 lower rate attendance allowance has been payable at £20·65 per week, higher rate attendance allowance at £30·95 per week, and mobility allowance at £21·65 per week. Thus a disabled person who is in receipt of either or both benefits might receive up to £52·60 a week. It is well established that disabled people incur extra costs, and to meet at least some of these costs it is important that all those who are entitled to these benefits are receiving them. In March 1985 it was estimated that 543 000 people were receiving attendance allowance and in February 1986 410 000 were receiving mobility allowance. Because the number of people in receipt of these benefits has been rising since they were introduced it is easy to assume that the benefits are taken up by all who are entitled to them. The results of several studies, however, show that some disabled people are missing out.

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Attendance allowance

Eligible:	Adults Children aged 2 years and over
Conditions:	(1) Needs frequent or continual help or supervision (see text) (2) Has needed this help for the past six months
Rates:	Lower – day or night rate: £20.65 per week Higher – day and night rate: £30.95 per week
Payable to:	Disabled person Parent
DHSS leaflet:	NI.205 "Attendance allowance"

Mobility allowance

Eligible:	Anyone aged 5 years and over Up to age 66 Payments stop at age 75
Conditions:	(1) Medical condition likely to exist for a year or more (2) Unable or nearly unable to walk (see text) (3) May be awarded with attendance allowance
Rate:	£21.65 per week
DHSS leaflet:	NI.211 "Mobility allowance"

A survey at a training centre for mentally handicapped adults in Harlow showed that 11 of the 100 trainees were eligible for but not getting attendance allowance. The results of another survey into the extra costs of living for mentally handicapped people showed that six of the 95 mentally handicapped people who were entitled to attendance allowance were not receiving it. In a study in Southampton of 205 mentally handicapped adults, though 69% were receiving attendance allowance, successful claims were made on behalf of a further 7%. In the same study Brown found that although initially only 10 mentally handicapped people were receiving mobility allowance, successful claims were made for another two. Cooke *et al* estimated that a fifth of the children who are eligible for mobility allowance are not receiving it.

Thus there is evidence that benefits are not claimed and also that disabled people and their families often go without attendance allowance and mobility allowance for considerable periods of time. The Disablement Income Group, which was founded 21 years ago, promotes the economic and general welfare of disabled people by carrying out research and running an advisory service. It is now carrying out research on the problems of the administration and take up of these allowances. This has included interviews with 105 people who recently claimed attendance allowance successfully and with 110 people who recently claimed mobility allowance successfully (samples were drawn from Department of Health and Social Security records). Forty eight per cent of the attendance allowance sample were entitled to claim the allowance earlier than they did. Of the 50 people with prior entitlement 21

(20%) could have applied five years ago or more. For example, a 40 year old mentally handicapped man who is almost blind and suffers from epilepsy has been entitled to attendance allowance since it was introduced, but his 70 year old father who cares for him has only recently found out about attendance allowance from a social worker. In another case, an unmarried woman caring for her 56 year old sister with Down's syndrome has only just found out about attendance allowance, although her sister attends a work centre for the disabled. The results of the survey of mobility allowance were even worse, as over half the sample (57%) had had prior entitlement to the allowance, and as many as 19% could have received mobility allowance at least five years earlier.

Finding out about the allowances

Almost a quarter of the sample had found out about attendance allowance from a doctor (either a hospital doctor or a general practitioner), but only 11% in the mobility allowance sample had found out in this way. Both groups of claimants eventually learned of these benefits from a variety of sources, mainly family, friends, colleagues, and other disabled people. Besides doctors, people such as social workers, occupational therapists, teachers, home helps, health visitors, nurses, physiotherapists, and social security officials played a part in informing these people about attendance and mobility allowances. An important finding from this research, however, is the perception that disabled people and their families have of the role of doctors and hospital staff in informing them about benefits or of the existence of benefits. Perhaps it is not surprising that such patients and their families feel that their doctor has let them down by not telling them about appropriate benefits because for many, especially the newly disabled, the doctor (whether in hospital or the general practitioner) is their first point of contact. The 70 year old man referred to above who cares for his mentally handicapped son said how annoyed he was that he had been without attendance allowance for his son for more than 10 years: "I feel that the doctor who has been attending my son for some years should have told me." Similarly, the woman caring for her sister with Down's syndrome felt "cheated because no one told me. I think hospitals and doctors should inform patients if there is a chance of entitlement and that there should be better publicity."

What doctors can do

When asked what can be done to make sure that people find out about and apply for allowances as soon as they become eligible 50% of the attendance allowance sample and 29% of the mobility allowance sample said that doctors and hospitals should do more. Thus to meet the needs and expectations of their patients doctors must inform themselves fully about disability benefits or find out where potential claimants may be referred for advice. The DHSS has not recently publicised attendance and mobility allowances and does not plan to apart from their leaflets which explain individual benefits (NI.205 "Attendance allowance" and NI.211 "Mobility allowance") and the handbook about non-contributory benefits. Where possible, therefore, these leaflets, which incorporate the appropriate claim form for benefits, and posters should be displayed in surgeries and hospitals to help to ensure that as many disabled people as possible find out about and claim disability benefits, which are rightfully theirs.

Not all disabled people, however, can visit surgeries or even read and understand the leaflets when they are on display. Doctors should carry such leaflets with them and also perhaps the leaflet describing the wide range of benefits that is available (leaflet FB.2 "Which benefit?") which is in Urdu, Gujerati, Hindi, Punjabi, Bengali, and Chinese, as well as English.

Doctors can also help their patients to claim these allowances speedily and successfully by sending a letter supporting the patient's claim form if asked to do so. If the attendance allowance and mobility allowance units request further information about a patient's condition it is important to reply fully and quickly. Unfortunately, doctors do not always send letters which are as helpful as they might be. For instance, a letter that states that a patient has a condition that will slowly deteriorate and that she needs help from her husband is not sufficient for the Attendance Allowance Unit to adjudicate on such a claim. Rather, information about what the patient can and cannot do, what he or she needs help with, and what the consequences would be if such help or supervision was not available is needed. Some doctors are reluctant to become concerned in such matters because of the many demands that are made on their time. But an investment of time in helping a patient to obtain these benefits may in the long run be cost effective. A person with improved finances from either of these benefits is likely to have better care and improved mobility and is therefore likely to make less demand on the doctor's time.

The research referred to in this article was made possible by a grant from the Nuffield Foundation.

Further information about the nature and scope of attendance allowance and mobility allowance, including checklists for applicants, and information about other disability benefits may be obtained from: The Disablement Income Group, Attlee House, 28 Commercial Street, London E1 6LR. Tel: 01 790 2424.

References

1 Baldwin S. *The costs of caring.* London: Routledge and Kegan Paul, 1985.
2 *House of Commons Official Report (Hansard)* 1986 February 26;29 (cols 600-1).
3 Bennett T, McGavin P. *Pyenest survey report.* Harlow, Essex: Harlow Community Services Department, 1981.
4 Buckle J. *Mental handicap costs more.* London: Disablement Income Group, 1984.
5 Brown R. *Money matters for people with a mental handicap.* London: Disablement Income Group, 1985.
6 Cooke K, Bradshaw J, Lawton D. Take-up of benefits by families with disabled children. *Children Care, Health and Development* 1983;9:145-56.
7 Department of Health and Social Security. *Non-contributory benefits for disabled people.* London: DHSS, 1984.

Accepted 8 July 1986

100 YEARS AGO

Advocates of alcohol are fond of declaring that we are temperate because we cannot drink, with impunity, as many bumpers as our ancestors. This is an argument full of fallacy; it depends upon the relative strength of wines at different ages of society, and upon what is meant by "impunity." Thackeray most rightly looked with suspicion on men still young, who spoke of themselves as "past" eating sweets. He believed that "all people who have natural healthy appetites love sweets." He was certainly right. Many practitioners have been struck with the readiness with which adult Englishmen eat sweets in these days, and remember that the heavy drinkers of thirty years ago, as a rule, detested sweets. The toleration of sugar is undoubtedly due to stomachs being stronger through temperance. A common physiological experience with regard to the impairment of digestion, is seen in beer-drinkers. A youth often drinks great quantities of beer with apparent impunity. At twenty-five, when his habits are becoming more or less sedentary, his taste for beer diminishes. At thirty-five, many men cannot tolerate a glass of beer. There can be little doubt that this change represents impairment of digestion; nor can there be great doubt that much of the depression, common amongst very young men, is due to attempts to keep up their strength by good living. Sleepiness and lassitude, interfering with afternoon work, are almost always due either to alcohol or to heavy meat-lunches. In a country where the *siesta* is not in vogue, a full mid-day meal, in the midst of work, is clearly unwholesome, especially when much alcohol is consumed. After a good breakfast, six hours' work, at least, can easily be done before a good dinner, allowing a cup of chocolate and a roll for lunch, excepting where much anxiety is incurred, or a considerable amount of physical exercise is taken. (*British Medical Journal* 1886;i:1221.)