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ONE MAN'S PRACTICE

by

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CHOICE OF SUBJECT

AFTER recovering from the initial shock of having been asked to allow my name to go forward for President, I began to cast around for a suitable subject for an address. Mr. Gallagher suggested 'The Changing Face of General Practice' but I did not feel competent to speak on it. Change is indeed inevitable but I try to slow its pace for I prefer to hold on to that which I think is good rather than rush to embrace the new. I considered telling you about some of my other interests but I have not studied any of them in sufficient depth to present them to this Society and none of them is remotely connected with Medicine.

I finally decided to tell you about my practice, which is single-handed, how it is run, and what I do in it. I have entitled my address 'One Man's Practice', implying that there are many different ways of running a practice, depending on the attitudes and personality of the doctor and the environment in which he works. Many may think that what I do is the way not to do general practice, but it suits me and seems to suit my patients. For the general practitioners in the audience I will be covering all-too-familiar ground, but there are many in this Society who are not engaged in general practice and it might help them to tolerate us better if they knew something of what is involved in the subject.

With the introduction of a Chair in General Practice at Queen's University, held at present by my old school-mate, Professor W. G. Irwin, the clinical standard of the general practitioner has been greatly enhanced. Those of us who

entered general practice in earlier years, however, have all evolved along different lines and no two of us are alike. This may be no bad thing, for it has offered variety and choice to the patient.

I have been told that there is, in our Province, a doctor who practices from the front seat of his car and patients queue to speak to him through the open window. Those who require more detailed investigation are directed to the comfort of a near-by shed. While many may consider this reprehensible, he has my full admiration, for anyone who can make a living in such a way must have great skill and immense personal magnetism. Provided there is a choice, and I understand that he is not the only doctor in the district, I would consider this infinitely preferable to a patient being forced to see someone in palatial surroundings whom he doesn't like or in whom he has no confidence. Buildings are no measure of clinical acumen.

I intend to deal with my subject in a superficial manner, for general practice is a broad subject rather than a deep one. Bearing in mind that there are usually many non-medical members in the audience at the opening meeting of the session, I hope to reduce technicalities to a minimum.

As past pressures have made me what I am, it will be necessary for me to give you a brief autobiography to enable you to understand my present position.

AUTOBIOGRAPHY

I was born in Toronto, Canada, and am still a Canadian citizen. My father died when I was six and my mother returned with me to her native Belfast. I was educated at Inchmarlo and Inst and on passing the Senior Certificate in 1941 I tried to join the Royal Air Force but was told I was too young. On the way home I called with a friend who lived behind Queen's University and he told me that he was going to study medicine. I was interested, so I collected the entrance forms to the Faculty of Medicine at the Registrar's Office and submitted them to my mother that night. She said that I could go to the university if accepted and I commenced studies in October 1941.

I qualified in December 1946 and was admitted to my first job in the Belfast City Hospital as house surgeon to the late Mr. H. P. Hall and Mr. Maurice Lavery, and developed a deep admiration for them both. I was then moved to Ava I and III as houseman to that forceful physician, Dr. S. R. Armstrong, whose vaccination classes are unforgettable. After this I was persuaded to accompany my colleague, Dr. Trevor Lawson, to Banbridge Hospital, the Light of whose Life lived, at that time, in Lurgan. Here we worked under Mr. H. W. Gallagher, whose prowess as a surgeon I have described on a previous occasion.

In July 1948 I went to Rathfriland to do a six weeks locum for the late Dr. John Shannon – and I have been there ever since! It was my ambition at the time to take a higher degree and return to my native Canada and I intended to leave Dr. Shannon as soon as we had cleared up all the work. Alas, this was never accomplished and I became even more deeply involved. It certainly was never my intention to stay in general practice for I was hospital orientated at the time and I longed to return to the warmth and security of hospital life.

Dr. Shannon was a superb doctor with immense energy and a tremendous sense of humour. He taught me a very great deal, including how to apply dental and obstetric forceps; there was ample opportunity to perfect one's skill in both for neither fluoride nor the 'Pill' had made their appearance on the horizon. The practice covered an area of some 300 square miles, and although Rathfriland was a small town, the surrounding country was thickly populated. The practice increased from 3,000 to 6,200 before the 1952 Danckwerts' Award, implemented in 1953, limited the figure to 5,500 for a principal and assistant.

The work-load was heavy, especially when either of us was on holiday. In 1948 I recorded having seen 127 patients in the surgery in one day. Home visits numbered 20 to 40 per day and once, when Dr. Shannon was on a fortnight's Refresher Course, my daily mileage averaged 120 miles. Needless to say, consultations were brief and notes were seldom taken. Most of the complaints were trivial but some serious conditions were mixed up among them and had to be watched for carefully. Having made no notes, I had a persistent worry in case something had been overlooked.

When conducting a surgery on my own I had the receptionist sitting at the desk, blocking out the prescription forms and the certificates as soon as the patient entered the room; she would write in the drugs or diagnosis as I dictated them to her and I only had to add my signature. One could always tell when a patient wanted to talk privately by the glint in their eye and such a patient would be shown into a separate room. With this system, some sixty persons might have been seen in two hours, after a fashion.

Home visiting had to be pretty brisk too to get all fitted into the day and to get back in time for the surgeries. Most of the obstetrics was carried out in the home and a diurnal maternity case could completely disrupt one's routine. The community was new-fangled at the idea of being able to call out a doctor at any time without having to pay him, and to be up five nights a week was not unusual. Not to get to bed at all for three consecutive nights was rare but did occur from time to time. 1948 to 1951 were probably the worst years and after that the population settled down.

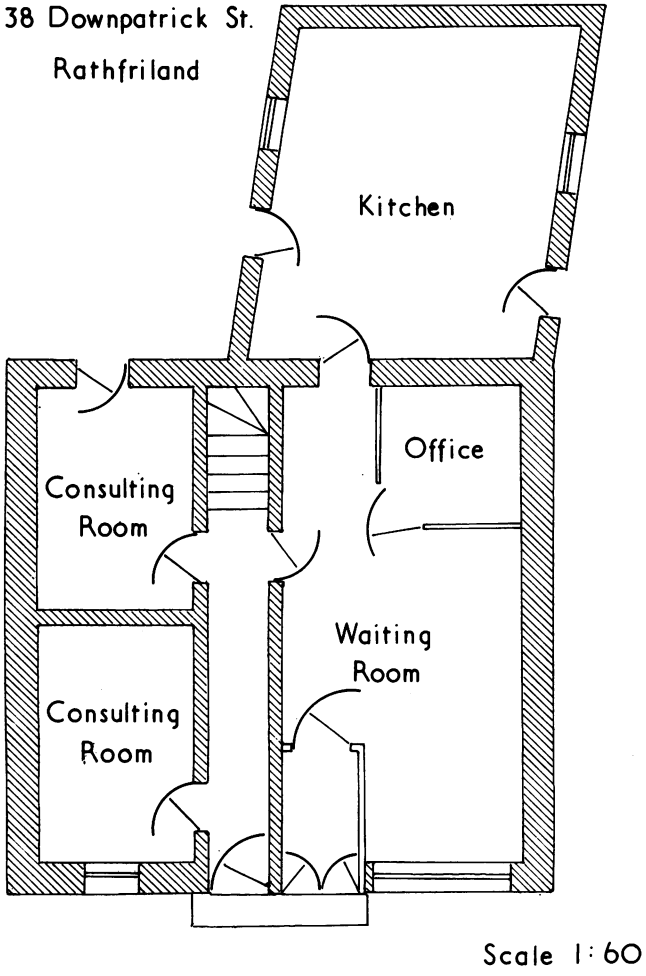
During this time one was kept up-to-date by meetings of the Banbridge Medical Club which met monthly and was addressed by many excellent speakers, including several Past-Presidents of this Society. Dr. T. T. Fulton was Physician to the Banbridge Hospital around this time and, as everyone knows, to read two of his reports covers the membership course pretty adequately!

In 1955 I read Lord Stephen Taylor's book "Good General Practice' and I developed a burning desire to put his precepts into action. An opportunity arose at the end of 1956 when the late Dr. Speedy retired. In February of the following year I bought an old public house and converted it into practice premises in which I still work. Some might consider it almost sacrilege to turn a public house into a surgery but I like to think that, as in former days, people leave the premises a little happier than when they entered!

I commenced practice in them on the 1st April, 1957.

THE PREMISES

As can be seen from the diagram (Figure), the ground floor consists of two rooms separated by the hall from the shop. The front room measures 12′ by 8′ and the back room 11′ by 8′. They are not too difficult to heat and the rear room has



a door opening into the yard which allows rapid ventilation if one has just dealt with a patient who has never heard of 'Lifebuoy'. The shop measured 24′ by 12′ and I converted it into a waiting room by removing the numerous shelves and counters, deepening the porch, and erecting a receptionist's office in the opposite corner. The door of the office opens outwards to allow maximum use of its floor area and the walls consist of wood and glass panels, the wood being carried to a sufficient height to prevent the patients feeling that they are

under constant supervision by the receptionist and the receptionist from feeling that the patients are breathing down her neck. The telephone is installed in the office and the clinical records are stored there. An intercom system operates between the office and the downstairs rooms, each of which has been furnished as a consulting room. There is accommodation for twelve patients in the waiting room and the heating is by oil and, in very cold weather, a Superser Gas Heater as well. From the beginning I have had a mains radio in the waiting room. The effect has been most interesting – when the radio is on, the patients either listen to it or shout above it. When it is off or away being repaired, they sit like wooden Indians – the sort that used to be seen outside tobacconist shops in North America – staring blankly at the opposite wall and there is no conversation whatever. I have purchased pictures for the waiting room and have been given gifts of others. I hang only one of them at a time as I hate clutter, and the picture is changed each week. Only one of the pictures is valuable.

Opening off the rear of the waiting room is a large back kitchen which I use as a workshop, a store for oil and gas, dressings, laboratory specimen containers, cleaning materials and a rowing boat. In the unlikely event of a flood submerging Rathfriland, I am, to some extent, prepared.

The hall acts as a sound barrier between the waiting room and the consulting rooms, thus complying with the requirement suggested by Lord Taylor in his book. The hall is 18′ long and, with a test card on the back of the front door, is of approximate length for testing distant vision. Lately however, I have put marks on the skirting boards at 3 metres for the more modern test card. At the rear of the hall a staircase gives access to six upstairs rooms.

Each consulting room is furnished with a desk, chairs, examination couch and wash-hand-basin, and is in communication with the office. Neither has a phone, so confidences cannot inadvertently be breached. I tend to use the rear room more than the front room as it is much quieter and contains the drugs and dressings. Heavy lorries climbing the hill up into Rathfriland can make auscultation in the front room almost impossible but not so in the back room.

Not to have been purpose-built, the old pub lent itself very well to my requirements without much alteration. Having two consulting rooms is an enormous advantage for one can, when pressed, deal with two patients almost simultaneously. When one leaves the room to allow a patient to get undressed or pass a sample of urine, one can take the next patient to the other room and get started without loss of time.

Although I don't make a practice of it, watching a patient get undressed can be quite revealing! I became interested when one old lady consulted me during a heat-wave in May 1968 and seemed to take an inordinate time in disrobing. After examining her, I surreptitiously made a list of her garments as she re-dressed. The items were as follows:

Vest, heavy knickers and stockings.
Flannel nightdress.
Pyjama coat.
Yellow cardigan.
Second yellow cardigan.
White shirt.
Green striped dress.
Pink blouse.
Heavy pleated skirt.
Heavy linen jacket.
Straw hat.

When she returned a week later, on the 14th May, I did not ask her to strip completely but I was interested to see what she was wearing. The list runs as follows:

Dark green pullover.
White vest.
Mustard cardigan.
Moss-green cardigan.
Dark blue cardigan.
Red pullover.
College blue cardigan.
White silk scarf.
Two heavy tweed skirts.
Brown jacket.
Thick tweed jacket.
Plastic raincoat.

According to my diary the 14th was a mild wet day, hence the raincoat. Now one might assume that the old lady was carrying her wealth on her back but this is not so. She owns a farm of 70 acres, and at a possible £1,000 per acre, she is not exactly in penury.

As can be imagined from the diagram, there is a flow, albeit intermittent, of patients into the waiting-room, thence to the consulting-room, and finally out through the hall door into the street. They are thus spared the embarrassment, especially if they have kept me an excessive length of time, of returning through the waiting-room to face the hostile stares of those still waiting to be seen.

When compared with modern specially-designed publicly-financed clinics these premises leave a lot to be desired, but they are compact and functional, and I can take some comfort from the words of Professor C. Northcote Parkinson when he writes, with his tongue in his cheek, 'Lively and productive institutions flourish in shabby and makeshift surroundings. A perfection of planned layout is achieved only by institutions on the point of collapse. Perfection of planning is a symptom of decay. Perfection is Finality and Finality is Death! The Palace of the League of Nations was not opened until 1937, by which time the League of Nations had practically ceased to exist'.

PRACTICE FROM 38 DOWNPATRICK STREET

On moving to the new premises I decided to change my method of working and to set new standards for myself.

First, I decided never to see a patient without having their clinical record in my hand or, failing that, a notebook in which I could write down the history and clinical findings.

Second, I resolved to try to solve every problem as it presented and to complete each task before moving to the next. In former days, when seeing 30 patients per hour, if anything sticky turned up likely to impede the flow of

consultation, I would ask the patient to return three days later, hoping that on that day I would be less busy. In point of fact, I was usually busier than I had been on the first day and detailed enquiry would be further postponed. This tended to swell the numbers at each succeeding surgery till the back-log reached frightening proportions. One knew instinctively that there was very little wrong with any of these patients but a single examination usually reassured them and terminated their frequent visits to the surgery.

Third, I decided to monitor the practice from a number of different aspects, some of which I shall describe to you later.

The Practice Week

I try to work hard on Mondays, Wednesdays and Fridays, and to free-wheel on Tuesdays, Thursdays and Saturdays. I don't believe in working on Sundays and am seldom called upon to do so. My receptionist takes her half-day on Tuesdays and stays in my home to pass messages to me in Belfast on Thursdays, hence my being able to be present here tonight.

The Consultation

The purpose of the consultation is to establish a diagnosis and to institute effective management or treatment. Diagnosis is usually made by listening to the story of the patient's illness and examining his person afterwards. Lord Taylor states that the tradition of English clinical teaching is to learn everything possible by clinical examination alone; to call in diagnostic aids only when clinical observation fails to give the answer; and to entrust these technical aids to those skilled in their use and interpretation. He avers that it is part of the pride of many English doctors, scientists, and lawyers, that they are oblivious to all but the essentials of their environment. They would suggest that it is the quality of the mind rather than the trimmings which matter and view the external manifestations of efficiency as meretricious etceteras, in all probability designed to hide an intellectual vacuum. To me, these high-flown sentiments contain more than a hint of inverted snobbery but, working as I do in a remote location, I find that I have to follow them.

Taking the History

Being aware of my diagnostic limitations, I listen attentively to all that the patient has to tell me, for often an apparently trivial detail may prove to be the essential clue to the solution of the problem. The detective-novelist R. Austin Freeman has his character, Dr. Thorndyke, say that 'The evidental value of any fact is an unknown quantity until that fact has been examined. All facts should be collected impartially without reference to any theory and each fact, no matter how trivial or apparently irrelevent, carefully studied'.

One Saturday morning several years ago, a mother-of-three came to see me privately. She was in great distress. She had been seen by two gynaecologists and didn't know which to believe. The first, whom we shall call 'A', had carried

out a number of operations on her cervix for recurrent cervicitis and had finally told her that the time had arrived for hysterectomy to be performed; he said that he was reluctant to do this as he felt she was psychologically unsuited for it but that nothing else would relieve her intense hypogastric pain. She had asked to be referred for a second opinion and she had seen gynaecologist 'B' a couple of nights before coming to see me. He had examined her and said that she didn't need her womb removed.

I was puzzled by the many relapses after diathermy and even amputation of the cervix and I let her run on for a while. It appeared that she had had a rather bad tear at the birth of her last baby and then she let slip that she had been unable to retain the enemas prior to the operations on her cervix, the fluid escaping from the vagina. A possible cause for the relapse was now apparent and it only remained to demonstrate the unnatural opening. I realised that each of my gynaecological colleagues had been covering the clue with his speculum. I passed a Spencer-Wells forceps into the anus and you can imagine my delight when I saw it project into the vagina! I now have some idea as to how Archimedes felt, for it was with difficulty that I restrained the urge to rush into the street to invite passers-by to witness my discovery!

I telephoned Mr. 'B' and told him what I had found and he advised me to notify Mr. 'A'. Mr. 'A' was not impressed and said it would have no bearing on her problem, so there I had to let the matter rest. About 18 months later I met Mr. 'B' who said that he had recently been at one of Professor Macafee's Clinics and this patient had been presented. The patient had been attending the Clinic for over a year and eventually one of the registrars had found the recto-vaginal fistula and plans were afoot to close it. I regret that, unlike Columbus, I was unable to mark my discovery with a flag!

Where the language is colourful, I follow Professor Lindsay's dictum to record the history in the patient's own words. In 1961 a perky 74-year-old visitor from Vancouver made an appointment with me for a 'complete check-over'. He had been in the Mounties in earlier life and was very spry for his age. Before commencing the examination I asked if he had had any serious illnesses. 'Nope!' 'Have you had any operations?' 'Nope – Yip! –I had an operation for piles about three years ago – and that was the end of sex for me! – and', he added ruefully, 'I'd just been married three months!' 'I went round to the doctor afterwards and I said "Doctor, when you operated on me last month' I reckon you must have *pared too deep!*".'

The Examination of the Patient

Time is an important factor in every human pursuit but it is especially important to a doctor on his rounds. Voltaire has pointed out that nothing is longer than time, since it is the measure of Eternity, but he goes on to say that nothing is shorter, since it is insufficient for the accomplishment of our projects. Nevertheless, since clinical examination need not be lengthy to be thorough, there is seldom any excuse for not examining a patient.

I usually begin by placing a thermometer under the patient's arm before starting to take the history. I prefer the axilla to the ends of the alimentary canal for it allows the patient to talk while the temperature is being recorded and obviates the necessity for cleansing and sterilising the thermometer afterwards. Adding one degree Fahrenheit to the result gives a figure sufficiently accurate for my purposes.

In the home, patients are usually confined to bed, and I have found that they can most rapidly be examined with the minimum loss of heat by first whipping the bedclothes down to the foot of the bed. Testing the plantar relexes, looking for oedema, checking for meningism and joint stiffness in a matter of seconds. The legs can then be covered while one looks for herniae, and superficial glands in the groins, axillae and neck. When a hand has been passed over the abdomen, this too can be covered while attention is paid to the heart, front of the chest, neck and upper limbs. When the patient sits up, I palpate for sacral oedema, auscultate the back of the chest, and then look at the throat. Eyes, ears and nose can be inspected when the patient lies back on the pillow. This can be achieved in less than two minutes, the patient does not become excessively chilled and a synoptic view of the patient as a whole has been obtained. If an abnormality is discovered, the portions of the body not being examined can be covered while it is scrutinised more carefully.

I follow much the same pattern in the surgery but here the patients are not usually feverish and their complaints tend to be of a more long-standing nature. Once again I begin at the feet and work up to the head, proceeding from the simplest to the most complicated part of the body. Many books on clinical medicine tend to examine the body system by system, but I think that to do so keeps the patient undressed for an excessive length of time. Of course, when writing up my notes I unscramble my findings into systems for subsequent rapid referral.

Examining the feet can be a rather unpalatable procedure. One young farmer with impaired vision stuck a graipe through his right foot one Thursday afternoon as I was preparing to leave for Belfast. I wasn't feeling very well at the time and was completely stuffed up with the cold. When he removed his boot there arose a miasma which, within three seconds, penetrated the innermost reaches of my skull and I was able to breathe freely for the next 36 hours. I have often wondered if this vapour could have commercial possibilities. It certainly lent some credibility to the local radio announcement that 'If the farmer who left his socks on the 4 o'clock bus on Friday will call at the bus station he can have the bus!'

Investigations

As a result of the history and examination the diagnosis may be self-evident, but if it is not, I list the possibilities and plan a number of laboratory tests to sort them out. If the diagnosis is still obscure I seek the help of a consultant.

I treasure the access to the laboratories, of which I have a choice of three, and, chiefly through habit, I use that at the Belfast City Hospital almost

exclusively. I would like here to pay tribute to the courtesy and efficiency of its staff, who have given me valuable advice on several occasions, suggesting tests that I did not know existed. Where appropriate, I also send samples to the Virology Department in the Institute of Clinical Science.

I am not really interested in open access to radiology departments except for X-rays of the chest for school-teachers, scuba divers and the like. As most of the lesions likely to be discovered on X-ray such as carcinoma of the stomach, gall-stones or pulmonary tuberculosis will have to be referred to the consultant in the long run, one may as well involve him from the start. Hospital consultants may have some idea of the work-load of their radiology department, but I, having none, might well swamp it.

Indeed I am glad *not* to have open access to X-rays for I might be tempted to have a patient X-rayed just in case something might turn up, and I do not think this is an adequate reason. I might also be spuriously reassured by a normal finding. I remember one man in his sixties, in hospital for three weeks for investigation for loss of appetite and strength, being sent home with a note saying that nothing abnormal could be found and that the barium meal was normal. On the night of his return home, his wife asked me to see him as he had just vomited half a bucketful of thin blackish fluid. When I visited him he had, in his epigastrium, a visible and palpable pointed craggy mass projecting like a miniature Rockall. A Past-President of this Society confirmed its presence and took him into his hospital. Repeat barium meal was again normal but laparotomy revealed an extra-gastric tumour.

In 1964 a short, stout woman consulted me for loss of appetite, weight and strength and, to my dismay, I found a lump the size of a goose egg in her upper abdomen. Fearing she had a carcinoma of the stomach I referred her for an urgent surgical appointment. Barium meal proved normal and arrangements were made for review in eight week's time. When she returned for the report the lump was still present so I referred her to another surgeon privately. He performed a left hemi-colectomy for a large adenocarcinoma of the colon. She had a local recurrence successfully removed by abdomino-perineal excision in 1974 and is still alive and doing well. In fact she and her husband visited their daughter in Smithers, British Columbia, this summer.

Clinical examination still has much to offer and I must say that I am deeply impressed by the high clinical standards exhibited by the recent outputs of our Medical School.

Treatment

Having made the diagnosis, final or provisional, one sets about organising treatment. Here a general practitioner may consider himself as seated at the console of a mighty therapeutic organ with a choice of manuals and stops. The great manual might be represented by those massive tomes, the British Pharmacopoeia, the British Pharmaceutical Codex and Martindale, and by the National Formulary. The swell manual might be represented by MIMS – the Monthly

Index of Medical Specialties – which is a list of the current proprietary drugs available, while the choir manual, mainly used for accompaniment, might represent the social services and their many workers. The pedal organ will represent those grand old fundamentals, aspirin, baking soda, and castor oil !

The ranks of stops on each side may be grouped in clusters of physicians, surgeons, obstetricians, paediatricians, geriatricians . . .each stop having its own function and tonal quality. Even as the pipe organ has its many registers, so has the therapeutic organ its abundant registrars. In the past, when selecting a consultant, I tried to match the temperament of the consultant with that of the patient so that harmony might ensue, but now, with so many registrars intervening between me and the consultant, I cannot be so artistic. I have nothing whatever against registrars for I am sure they do most excellent work, but they seldom stay long enough in the one place for me to get to know them and assess their various capabilities.

To ensure that patients see the consultant of my choice, I recommend them, if they can afford it, to seek a private consultation. Naturally I can only advise them to part with their money to a specialist whom I know to be both competent and conscientious, and for me to have formed such an opinion, he must have done good work on my general patients. I believe that private practice within or alongside the Health Service can be beneficial by stimulating the need for maintaining or raising the standards of care. In my opinion, C.O.H.S.E. and N.U.P.E. have adopted a myopic attitude in opposing it, for those whom they seek to protect are those who are likely to suffer most.

Some consultants have silver tongues while others are very down to earth. Some are verbose and expansive, giving many patients great confidence, but some patients are suspicious of anyone who talks too much. I remember referring one such man to a consultant who was inclined to be rather dry and uncommunicative and warned the patient not to expect him to say too much. Quietly he said to me "Them as *knows* most *says* least, and them as *has* most *gives* least."

Home Visits

Not all the work of the practice is done in the surgery, for home visiting still provides a significant though diminishing proportion. It seems to have died out completely in the United States but I would not like to see it disappear altogether for I enjoy driving round the countryside admiring the scenery, the vegetation and the animal life. The country is particularly beautiful in the Spring but each season has its own charm. Acute infectious disease, cardio-respiratory disorders, the acute abdomen and geriatrics are the main reasons for these visits. Now that more people own cars, more come to the surgery. A dearth of fuel may soon reverse the balance.

Receptionists

To assist me in my work I employ a receptionist. In 22 years' practice from Downpatrick Street I have employed three receptionists. The first left to get married after nearly two years, the second left to train as a nurse after nearly three years, whilst the third, a married woman, is still with me. They have all been excellent and none of them has had any special training for the job. Indeed, I would prefer someone who wasn't trained and who was not in possession of any fixed ideas. It is not difficult to show them what one wants and they can pick up the essentials pretty quickly. I would be more concerned that they had a pleasant personality and a friendly and helpful attitude towards my patients than that they should be geniuses in their own right. Happily they have all been very bright as well as considerate towards the patients.

From the beginning I have paid them all a bonus as well as a salary. I increase the salary by small amounts twice a year and the bonus is related to the number on the list and to the maternity fees and immunisation fees which I receive for the quarter in question. As the latter tend to fluctuate, so the bonus is greater at times than others. I think that the variation in remuneration of an employee with the ebb and flow of business gives them a sense of involvement, and makes them almost partners. My receptionist makes no demur when her pay cheque is down but I do get puzzled inquiries from the Central Services Agency. Perhaps trade unionists would not approve.

My receptionist knows the practice almost better than I do and her duties are many and varied. Locums always compliment me on her and I am fully aware how lucky I am. I know that some doctors regard their receptionists as buffers between themselves and the patients but I prefer to regard mine as a link.

THE STATISTICS OF THE PRACTICE

Volume of Work

The volume of work is indicated by Table 1. The surgery attendances have steadly increased throughout the years so that the number in 1978 is about twice what it was in 1958. The number of home visits, however, after an initial rise, fell by 1978 to less than half what they were during the nine months of 1957. Adding attendances and visits together gives a fairly constant figure of between 8,000 and 10,000 per annum, while dividing the number of visits into the number of attendances to obtain the A/V ratio shows a progressive rise from 1.13 to 6.69 over the 22 years. The mileage travelled in 1957, some 11,000 odd miles, gradually rose to 20,000 by 1966 before falling back to its original level in 1978.

Mortality and Age at Death

It is difficult to measure one's performance in general practice but two of the yardsticks – note that I am still an imperialist – that I use are the death/rate per 1,000 and the average age at death for each calendar year. The death/rate for Northern Ireland, County Down and the United Kingdom is a fairly stable figure but my death/rate fluctuates widely (Table II). I am bound to lose patients sometime and some years there is a heavier crop than others! A Newry undertaker used to have a sign in his window which said "If you don't die, we can't live."

TABLE 1

Volume of Work in Practice

Year	Surgery Attendances	Visits	Services (Attendances + Visits)	A/V Ratio	Annual Mileage
1957 (9 months)	2950	2613	5563	1.13: 1	11,296
1958	4052	3503	7555	1.16: 1	15,536
1959	4867	3614	8481	1.34: 1	16,695
1960	5016	3329	8345	1.51: 1	16,941
1961	5352	4204	9556	1.29: 1	18,338
1962	5366	3531	8897	1.51: 1	17,937
1963	4539	3286	7825	1.38: 1	18,758
1964	5136	3114	8250	1.65: 1	18,278
1965	5506	2715	8221	2.02: 1	19,669
1966	5120	2937	8057	1.94: 1	20,460
1967	5680	2704	8384	2.10: 1	18,842
1968	6289	2911	9200	2.16: 1	16,616
1969	6609	2408	9017	2.74: 1	15.973
1970	6676	2135	8311	3.12: 1	17,885
1971	6979	1746	8725	3.99: 1	15,266
1972	7169	1675	8844	4.28: 1	15,288
1973	7542	1643	9185	4.99: 1	14,777
1974	8250	1561	9811	5.28: 1	12,546
1975	8204	1512	9716	5.42: 1	13,305
1976	8684	1531	10,215	5.67: 1	13,203
1977	8329	1381	9710	6.03: 1	15,786
1978	8452	1262	9714	6.69: 1	11,419

TABLE II

Deaths in Practice and Mortality Rate

	Number of Deaths			Rate/1000		
Year	Total	Male	Female	Practice	N.I.	Co. Down
1957	6	1	5	7.6	10.9	10.9
1958	9	7	2	9.7	10.8	10.9
1959	5	3	2	4.9	10.9	11.1
1960	4	2	2	3.6	10.8	11.1
1961	9	7	2	8.1	11.3	11.4
1962	10	4	6	8.7	10.6	10.7
1963	8	5	3	6.7	11.0	10.8
1964	13	5	8	10.8	10.5	10.4
1965	11	5	6	8.8	10.6	10.7
1966	16	8	8	12.6	11.1	11.1
1967	8	3	5	6.1	9.8	9.6
1968	12	7	5	8.8	10.6	10.6
1969	13	8	5	9.1	10.8	10.8
1970	9	2	7	6.1	10.9	11.1
1971	11	8	3	7.4	10.6	10.8
1972	18	11	7	12.1	11.0	11.1
1973	15	8	7	9.7	11.4	11.2
1974	10	6	4	6.3	11.2	N/A
1975	17	11	6	10.7	10.7	N/A
1976	12	6	6	7.4	11.1	N/A
1977	16	7	9	9.9	11.0	N/A
1978	13	5	8	7.9	10.8	N/A
	245	129	116	8.3	10.8	

Table III shows the ages attained in my practice in South Down which go to make up the averages. As you can see infants are included, thus pulling down the average age of death. No figures are available for the average age at death in the United Kingdom.

TABLE III

Age at Death in Practice

Year	Age of Patient	Average Age	
1957			
	M. 46.	46.0	72.8
	F. 91, 87, 78, 73, 62.	78.2	
1958			
	M. 86, 80, 74, 69, 55, 46, 3.	59.0	61.0
	F. 82, 54,	68.0	
1959			
	M. 78, 67, 55.	66.6	69.0
	F. 74, 71.	72.5	
1960			
	M. 83, 8.	45.5	61.8
	F. 83, 73.	78.0	
1961			
	M. 85, 78, 73, 72, 41, 13, 2.	52.0	58.0
	F. 84, 74.	79.0	
1962			
	M. 83, 74, 73, 51.	70.2	53.7
	F. 84, 66, 66, 36, 3, 1.	42.7	
1963			
	M. 86, 70, 56, 55, 53.	64.0	67.8
	F. 80, 71, 71.	74.0	
1964			
	M. 73, 72, 69, 53, 30.	59.4	66.5
	F. 88, 83, 80, 79, 78, 68, 61, 30.	70.9	
1965			
	M. 88, 81, 63, 60, 55.	69.4	77.1
	F. 93, 90, 89, 86- 80, 63.	83.5	
1966			
	M. 86, 80, 77, 70, 66, 63, 54, 1.	62.1	71.9
	F. 94, 87, 87, 84, 82, 79, 73, 68.	81.8	
1967			
	M. 93, 69, 1.	54.3	60.6
	F. 86, 84, 78, 73, 1.	62.4	
1968			
	M. 83, 80, 79, 76, 62, 44, 37.	65.8	68.6
	F. 92, 74, 74, 72, 51.	72.6	
1969			
	M. 79, 76, 72, 72, 66, 65, 56, 1.	60.9	63.1
	F. 94, 85, 84, 69, 1.	66.6	
1970			
	M. 82, 70.	76.0	63.4
	F. 93, 81, 81, 78, 53, 32, 1.	59.9	
1971			
	M. 87, 75, 70, 70, 66, 55, 44, 10.	59.6	57.0
	F. 89, 60, 1.	50.0	
1972			
	M. 88, 80, 78, 76, 73, 68, 68, 46, 34, 2.	61.7	67.1
	F. 88, 82, 79, 78, 75, 65, 62.	75.6	
1973			
	M. 84, 81, 72, 70, 65, 64, 60, 53.	68.6	65.6
	F. 78, 75, 74, 71, 68, 68, 1.	62.1	
1974			
	M. 85, 80, 78, 70, 67, 53.	72.1	69.6
	F. 95, 91, 76, 1.	65.7	
1975			
	M. 87, 87, 84, 82, 75, 74, 69, 63, 62, 56, 45.	70.7	70.7
	F. 89, 87, 78, 69, 64, 37.	70.6	
1976			
	M. 81, 77, 70, 66, 57, 56.	67.8	72.6
	F. 85, 82, 81, 81, 76, 59.	77.3	
1977			
	M. 92, 84, 76, 56, 51, 49, 38.	63.7	69.5
	F. 96, 88, 82, 78, 74, 71, 67, 64, 46.	74.0	
1978			
	M. 88, 78, 71, 66, 64.	73.4	74.8
	F. 96, 85, 80, 79, 75. 72, 60, 58.	75.6	

Place of Death

About half of the patients died at home and half in hospital. The figures were 121 and 116 and another 8 died elsewhere. These included one who was drowned in the River Lagan, one collapsed and died while driving to work, one collapsed

TABLE IV

Causes of Death

Cardiovascular Disease

Coronary occlusion	44
Cerebrovascular accident	31
Cerebrovascular disease	13
Congestive heart failure	11
Left ventricular failure	8
Pulmonary embolism	6
Valvular disease of heart	4
Ruptured aneurysm	3
Arterial disease	2
Congenital heart disease	1
Fibroelastosis of ventricle	1
Malignant hypertension	1
Myocardial degeneration	1
	126

Average age at death = 70.6 years

Malignant Disease

Carcinoma stomach	7
Carcinoma lung	6
Carcinoma prostate	4
Carcinoma breast	3
Carcinoma gut	3
Carcinoma ovary	3
Cerebral tumour	2
Leukaemia	2
Mouth and ENT	2
Mediastinal tumour	1
Melanoma	1
Carcinoma oesophagus	1
Carcinoma pancreas	1
Retroperitoneal sarcoma	1
	37

Average age at death = 60.8 years

Other Causes

Bronchopneumonia	16
Miscellaneous	14*
Renal Failure	10
CNS disease	6
Chronic bronchitis	6
Fractured femur	6
Pneumonia	6
Virus pneumonia	4
Hepatic cirrhosis	3
Spina bifida	3
Bronchiectasis	2
Intestinal obstruction	2
Road Traffic accidents	2
Blood dyscrasia	2
	82

Average age at death = 64.0 years

***Miscellaneous**

Acute adrenal insufficiency	1
Acute tracheobronchitis	1
Asthma	1
Cot death	1
Diverticulitis — haemorrhage	1
Drowning	1
Gastroenteritis	1
Gastrointestinal haemorrhage	1
Meningococcal septicaemia	1
Pulmonary tuberculosis	1
Q Fever	1
Scalding	1
Splenic anaemia	1
Suicide	1
	14

in the street from aortic stenosis, one collapsed during physical training, two died in cars on the way to hospital and two were killed in road traffic accidents.

Causes of Death

When I came to study the causes of death of my patients I soon realised that they could be conveniently divided into three main groups —

Cardiovascular Disease	—	126 (51.4 per cent)
Malignant Disease	—	37 (15.1 per cent)
Other Causes	—	82 (33.5 per cent)
		245

I was surprised to find that the first two together caused two-thirds of the deaths and if the whole problem of malignant disease had been conquered only 15 per cent of my patients would have been saved. The causes of death are studied in more detail in Table IV. It is interesting that there were more deaths from coronary occlusion than from all forms of malignant disease put together. For me the most significant figure in the whole list is the single death from pulmonary tuberculosis – dramatically different from what would have been recorded thirty years ago. With many patients there were contributory factors bringing about their demise, but in each case I have tried to select the main cause.

Enough of these statistics lest we acquire the "Paralysis of Analysis".

VARIOUS ASPECTS OF PRACTICE

Appointments

I do not run an appointment system for three main reasons. First, I know that I would be unable to keep up to time, and if I did not do so, I could hardly expect the patients to be punctual.

Second, I like to think that any of my patients can see me within an hour or two of taking the notion to do so. I have always been afraid of someone who has had difficulty in screwing up their courage to consult me for, say, a lump in the breast, being put off by having to make an appointment.

Thirdly, I can spend as long as I think necessary with each patient for I know that those in the waiting-room must have a complaint that they consider of sufficient gravity as to be worth the wait. When a patient is consulting me my thoughts are concentrated on trying to identify the problem and to solve it; I am able to forget about how many are in the waiting-room. It used to be said that one should treat each patient as though he was one's only patient, and I think this is sound advice; if the patient's problem isn't solved on the spot, he will be back to trouble one in the future. Once the diagnosis has been made, follow-up need only take a couple of minutes.

Certificates

The issue of certificates forms a significant and irksome proportion of the work in general practice. Some certificates are "official," such as those for sickness and accident benefit, expected confinement and death, the issue of which is obligatory, while others are "private" and may qualify for a fee.

Private certificates are given to satisfy employers for absence from work, school authorities for absence from school or unfitness for games, insurance companies for sickness and accident, and the housing executive for points in securing the tenancy of a house.

An unusual request for a private certificate was made to me a few years ago when a young lady came to see me privately and asked me to examine her and give her a certificate to say that she was a virgin. I asked who required the certificate and she replied that her boy-friend did. I asked her why he wanted it and she told me that he had said that she wasn't a virgin. I asked her what made him think so. She said that he had been "fiddling around" the previous night and found that she wasn't. I asked her where he had obtained his experience but she did not know. I told her to tell her boy-friend to accept her as she was or else to change her boy-friend. I then asked her for two guineas. She said "What for – you didn't examine me!" I told her it was for the advice and that it was cheap at the price. When I bumped into her about a year later she told me that she had changed her boy-friend shortly after being with me. Advice that is paid for may sometimes be followed.

Chemists

There are two chemists in Rathfriland and one in Hilltown, which is three miles away. They are exemplary men, willing to oblige me or my patients at all hours of the day or night. I regard them as – dare I use the word? – indispensible! Pharmaceutical chemists play a very important, if unobtrusive, part in the Health Service and richly deserve the support of the medical profession. They often find it difficult to obtain locums and may go for long periods without a vacation. It is usually when one of them retires or gives up his shop that his true value to the local community is realised.

I hope that their profession may become sufficiently attractive to recruit eager young men and women into it.

The Clinical Record

The present clinical record is a cardboard envelope, 7 inches tall and 5 inches wide and has been in use since 1920. The back of the envelope is ruled for notes while the front bears the fundamental details of the patient, with a discreetly narrow space at the bottom for the date and cause of death, reminding us of our mortality.

The envelope is easily stored and handled and can hold continuation cards for notes and the correspondence relating to the patient. Hospital stationery used to measure about 8 inches by 6 inches and, with a single fold, could be fitted into the clinical record with ease. Now it comes in all shapes and sizes and some quite small sheets, because of their square shape, have to be folded in four in order to be stowed, causing the record to bulge in the middle and perhaps split at the sides. Envelopes with gusseted sides have been introduced, but even these can be stretched beyond their capacity by patients with a penchant for ill-health.

Moves are afoot to replace these envelopes with folders but problems of cost, storage, and the labour of transferring information from one system to the other have been encountered, and I, for one, hope to have left practice before they are introduced.

Disease Patterns

The pattern of disease in my area has changed considerably over the past thirty years. Generally speaking, apart from tonsillitis and urinary tract infections, bacterial diseases have tended to disappear, while viral diseases, with the exception of poliomyelitis, have continued unabated. Acute abdominal emergencies also seem to be less common. Rheumatic fever, erythema nodosum, and nephritis which used to follow streptococcal infections are now seldom seen, and I have never seen a case of *acute* mastoiditis. Diphtheria, I am glad to say, had almost disappeared before I came on the scene, and I have only encountered four cases in my life. Nevertheless, I always remember Dr. Freddie Kane's dictum "The examination of a sick child is not complete until its throat has been seen" – not always an easy task ! Meningococcal infections seem rare in rural areas but I did have one case which was rapidly fatal, while leptospiral jaundice seems to have disappeared from our area. Chickenpox, glandular fever, measles, mumps and rubella continue much as before, while sporadic cases of influenza occur throughout the year. The biggest change in the incidence of serious infectious disease has been the conquest of tuberculosis and poliomyelitis. We must, however, remember the analogy that the "price of peace is eternal vigilence".

As old diseases disappear, new ones are bound to spring up, such as the illness that afflicted the man who ate the steak that came from the steer that nibbled the grass that grew in the field where roamed the cat that caught the bird that ate the fish that fed on the bug that floated around in the oil slick !

Personal Behaviour

To enable me to extract the maximum from myself I have adopted a code of behaviour, which, like Common Law, though not written down, I observe as rigidly as if it were. I have mentioned some features of it earlier on, such as never seeing a patient without having his clinical record in my hand, treating every patient as if he was my only patient, and trying to solve each problem as it arises.

I try to attend to a request for a visit out of hours as soon as the message comes in, otherwise it tends to rankle with me. I keep the telephone in the bedroom some distance from the bed so that I have to get up to answer it — as

soon as my feet touch the floor I am immediately awake. When I am absolutely exhausted and am asked to see yet another patient, I steel myself for the effort by telling myself that this is the most important case I have seen all day, for I am always afraid of missing something serious when I am tired; general practice is not a difficult subject but it does involve keeping on keeping on. The late Dr. J. C. Smyth, who was both a dentist and a doctor, once told me that he had been taught always to wash his hands in front of the patient, even if he had just washed them and I try to follow this as far as possible.

There is an old saying "Never make friends of your patients and never make patients of your friends." I have broken the first rule many times but I make every effort to observe the second rigidly. So far I have not regretted making friends of my patients and indeed they have become almost members of my family, —perhaps that is what is meant by the term "Family Doctor'. I dont know if such relationships can be established in multi-doctor practices or even if they are desirable, but for me they provide a continuing interest.

In times of stress I unashamedly admit that I call upon my Maker for assistance. This is not unknown in other spheres of activity. My son, when training as a pilot in the Royal Air Force, told me of one young flyer who, after beating up the airfield and narrowly missing an obstacle at the far end, was heard to say over the intercom "O.K. Jesus! — Have control now! "

Single-handed Practice

Much can be said in favour of practicing in partnerships, groups, and from health centres, but I have come to enjoy solo practice for the following reasons:

First, I don't have my sensitivities bruised by seeing a patient come into the surgery and then opt to consult a colleague – anyone who enters my premises has come to see me – if they hadn't, they would have gone elsewhere; the consultation therefore starts off on a basis of mutual trust as I know that I am not being seen under sufference.

Second, I can follow each patient's illness from the beginning to the end and make adjustments to the management as I go along; I can alter the diagnosis or treatment as I think fit without undermining the patient's confidence in an associate.

Third, I have to accept responsibility for my own actions and I do not have to 'carry the can' for anyone else.

Fourth, I can't complain about getting the heavy end of the stick; if there is any work not done in the practice. I have no one to blame but myself, and as I know that it will have to be done sometime, I try not to let things get behind.

Finally, solo practice prevents me from becoming too powerful – it is good for me to realise that a patient can transfer to another doctor if I don't give him satisfaction; I consider that allowing patients to "vote with their feet" is preferable to having them report one to the Central Services Agency or sueing for negligence.

Varied Roles

Along with his clinical work, a general practitioner has many roles thrust upon him, many of them time-consuming. The appointment of a state pathologist in 1958 and the development of his department has lightened the load of the medico-legal work and has abolished the farce of the coroner's inquest, where I was sometimes asked to pronounce on the cause of death from a view of the deceased's face.

Solacing unmarried mothers-to-be and listing their options remains a fairly frequent task in spite of the prevalence of "The Pill". Twenty-five years ago it was not uncommon to be summoned by parents to young girls with supposed appendicitis and have to modify the diagnosis to that of imminent parturition, the arrival of the infant confirming my opinion.

Reconciling estranged marital partners is also a lengthy undertaking and, for me, there is no licence fee for 're-marrying' them, but I suppose a feeling of satisfaction is sufficient reward.

Comforting the dying, usually from cancer, when the mind is clear and the body frail, can be rather depressing, especially when philosophical subjects such as the "Meaning of Life" and the question of "Life after death" crop up, but sometimes the conversations can be enlightening or even amusing.
Harry B. had suffered severe pain in the back from secondary carcinomatous deposits from the pancreas for a year and a half; it was six months after the onset that he became jaundiced and the site of the primary was recognised. Joining the gall-bladder to the duodenum, thus by-passing the growth, relieved the jaundice, but the backache continued with increasing ferocity. Towards the end, I asked him if he regretted his many months of agony. After a pause, he replied that he didn't; he said that although he hadn't been a bad man, he hadn't been a good one either, and the past few months had allowed him to set things right with his Maker before he made the final transition. The pain was so severe that he longed to die and one morning he told me that he had had a strange dream. He dreamt that he was in a field with a stream at the bottom of it and across the stream, in another field, he saw Jesus standing – "It was the beautifullest place I have ever seen – There is just nothing like it on this Earth ! I said 'I'm coming, Jesus! ' and He said 'Not yet, Harry, not yet." Was this a drug-induced hallucination or a glimpse of the 'Life Beyond' ?

In either case, it brought him great peace and, a few days later, on the morning of his death, he woke at 6 a.m., settled his remaining debts by cheque, and died quietly at 8 a.m.

Wives in General Practice

Wives are virtually essential and, doubtless, essentially virtuous, in general practice. They receive and record messages during the day when the practice staff are off duty or are otherwise unavailable, and during the night when the doctor is out on a call. They offer hope, reassure, and bring words of comfort to those who seek the doctor when he can not be found. They feed, clothe and support the doc-

tor in his times of stress and receive much of the irritation which he would have liked to have vented on the real culprit for his ill-humour. I therefore pay tribute to all those wives who have done so much for medicine throughout the province whose faithful service is seldom recognised, and I offer a special word of thanks to my own wife for her tolerance, patience and unfailing support.

CONCLUSION

In conclusion, I would like to thank you all for enduring me so patiently. If this address has seemed long and tedious, then I have been successful in creating the atmosphere of an average day in general practice; I have not mentioned obstetrics, as this generally occurs at night and I have no wish to weary you any further. I realise that the address has been a sequence of inconsequentialities, but so is general practice, for it is the acne, bronchitis, colic, dandruff, eczema, flu, gastro-enteritis, headache, impetigo, jaundice, kerion, light-headedness, mental depression, nervousness, obesity, pyelitis, quinsy, rheumatism, sinusitis, tonsillitis, ulcers, verrucae, whitlows, and the XYZ of trivia which form the bulk of a general practitioner's work and it is only occasionally that one sees an interesting case, usually of serious import for the patient.

I feel that successful medicine will always depend on a satisfactory doctor/patient relationship however sophisticated our methods of diagnosis, treatment, and organisation become, and since a man is greater than the sum of his parts, I hope there will always be doctors who will look after the patient as a whole.

As I said at the beginning, I never intended to do general practice but, looking back over the years, I am convinced that there is no other field of human endeavour in which one can offer so much help, physically, mentally and, perhaps, Spiritually, on an intimate basis to so many people.

After this sanctimonious statement, I would like to end on a serious note: —

Twenty-four hours a day they seek
His help on seven days a week.
He rushes at the 'phone's shrill peal
Out of his bath or from his meal.
They button-hole him in the street;
They drag him from his theatre seat.
He settles to a game of bridge
And someone has a haemorrhage.
And when, at last, his race is run,
When his last journey has begun,
They'll come and say in accents terse
"Is there a doctor in the hearse?"