Obituary

MONTAGU OWEN KENT-HUGHES

M.B. B.S. (Melb.), F.R.A.C.G.P., F.R.C.G.P.(Hon), M.C.F.P.C.(Hon)

Born in Melbourne, Victoria 1906, Montagu Kent-Hughes died there on 5 January 1976.

" The mercurial Montie is dead. Most of us imagined that this could never happen. There were progressive signs, of course, that it would, which he with customary fortitude ignored and we with our defence mechanism against anxiety, denied."

So wrote Andrew Fraser in the *Australian Family Physician*, expressing the feelings of all of us. The last full day I spent with Montie was in Perth, where he attended the Annual General Meeting of our College and received the Rose Hunt Award bestowed on those rendering outstanding service to the College's aims and objectives, " be they patient care, educational research, organisational, or any other services ". During this last day together we visited friends, who all sensed it was farewell. Shortly after I came home, I received a note of thanks for a happy day, his last written message to me.

Such was the spirit of Montie that to enumerate his many qualities is not possible in an obituary. Sufficient to say that they were an elegant mixture of many genes: Welsh, Norman, Anglo-Saxon, and possibly others. During one unguarded moment he told me he was a direct descendant of the Maid of Kent: a dangerous admission to an Australian. In times of stress, as when meetings threatened to get out of hand, he was always at his British best. Calmly, but firmly, he would show the way to a peaceful and a proper solution. Of course, there were times when his far-seeing imagination initiated confusion, but he never bore ill-will to anyone.

Montie had three major professional interests, the Royal Australian College of General Practitioners, group medicine, and general/family practice at the international level. These three interests were always in the forefront of his mind. His many other activities stemmed from them. What bound them together was his determination to give of his best and to encourage others to do likewise in the service of mankind.

In the beginning, his ambition was to establish a multi-disciplinary group practice at Moonee Ponds, a suburb of Melbourne. He never lost his faith that this form of practice could give patients and their families the benefit of a wide range of health care at the community level, in the clinic, in their homes, and in hospital. Nevertheless, he was always tolerant, a quality exemplified when he asked me, a confirmed solo doctor, to be President of the National Conference which set up the Group Medicine Management Association of Australia.

As soon as it was suggested, Montie became an active campaigner for an Australian College of General Practitioners. Soon he became recognised as our leader in the field of education and training for and in general practice. An omnivorous reader with a vivid, but practical imagination, he brought to the Education Committee the pabulum which made it possible to design programmes and an examination suited to Australian conditions of practice. These will be his lasting memorial.

In time, it was inevitable that Montie should turn his attention to the international scene. He had forged links by correspondence with colleagues throughout the world. He was recognised as the Australian authority on education and methods of evaluation.

In 1964, he attended the First International Conference on General Practice organised in Montreal by the Canadian College. From then on he travelled widely to promote the formation of a world organisation. Usually he moved so quickly, physically as well as mentally, that an American friend described him as " a comet passing overhead with a long tail of light that is bright with new ideas ". The culmination of his hopes came in Melbourne in 1972 when the " World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians " was founded. He was elected Inaugural President.

Montie was always a reluctant office-bearer. He could never be merely a figure head. He was concerned with action. He was President of the Royal Australian College of General Practitioners 1968–1970; Inaugural President of the Group Medicine Management Association of Australia; and Director of the Melbourne Medical Postgraduate Committee Intern Matching Service. He will always be remembered for the many things he has done, but he will always be loved because of his warmth, humility, and his concern for people.

In the words of his daughter—" He was such a gentle, understanding person ".

For those of us who had the privilege of working with him, the memory of Montie will always be an inspiration and a challenge. He saw the vision splendid. So must we.

C. JUNGFER

CORRESPONDENCE

LOOKING AFTER PATIENTS WITH HIGH BLOOD PRESSURE

Sir,

In your recent editorial, *Looking after patients with high blood pressure* (April *Journal*), you refer to a history of headaches (type unspecified).

Pickering (1968) in his classic text points out that " headaches are more conspicuous in those who are anxious, as are patients who have just been told that their arterial pressure is high ". He then goes on to describe the features of one type of headache which is commonly associated with gross hypertension. Happily the great majority of hypertensive patients in day-to-day practice do not suffer from gross hypertension.

Similar observations have been made by other workers, e.g. Stewart (1973) and the *British Medical Journal* (1973) editorial.

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Sir,

The importance of the clinical examination of the hypertensive patient is given too little weight in your editorial (April *Journal*). Baseline information about the state of the peripheral pulses is invaluable, particularly as these patients have a high prevalence of peripheral vascular disease.

Attention to the femoral pulses is necessary to pick up the rare case of coarctation of the aorta. Careful palpation of the cardiac apex is an extremely important, but all too often neglected part of the physical examination, and may provide evidence of left ventricular overload before the electrocardiogram or chest x-ray become abnormal. The apex is palpated first in the recumbent position to determine its site and then in the left lateral position to determine its character. The normal apex presents a brisk outward movement at the onset of systole, quickly receding in mid to late systole; the hypertrophied left ventricle shows a more sustained thrust which increases throughout systole before fading at the onset of diastole (Conn and Cole, 1971). Left heart disease may be picked up at an even earlier stage by the finding of an atrial gallop. (Bethell and Nixon, 1974.)

The presystolic atrial impulse is often easier to feel with the finger tips than to hear through the stethoscope; the atrial sound may best be heard with the bell of the stethoscope placed very lightly on the apex. The disappearance of the atrial gallop following control of the blood pressure is a good indication of successful treatment (Kincaid-Smith and Barlow, 1959).

The long term management of a chronic condition like hypertension requires more than a single observation of the various clinical features, laboratory findings and electrocardiographic and x-ray changes. Regular checks of some parameters are necessary to ensure that control is not only cosmetically satisfying, but also physiologically effective. An efficient recording system is essential to this task, and the flow sheet, an integral part of the problem-oriented medical record, is ideal for the purpose (Bjorn and Cross, 1970). Columns for blood pressure, weight and drug dosage are filled in at each attendance, while columns for apex character, fundal appearance, peripheral pulses, blood potassium and urea, chest x-ray and electrocardiogram can be completed less often. A glance at the flow sheet shows not only the efficiency of blood pressure control, but also sequential changes in other important observations and when they should be repeated.

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