GENERATIONS OF PRACTICE

General practice in the jet age

JOHN CHALLENOR

General Practitioner, Plymouth

This is the first of a series of two articles about a unique general practice attachment.

With some apprehension I watched the silver bird tilt precariously over the green undulating landscape of South Devon; then, still silent, slipping downwards gently towards the landing strip. Exeter Airport, a tiny international gateway to South West England. Surely there would be no culture-shock here for my octogenarian grandfather, Dr Bertie Daniels MD.

MY musings as to the changes he would find since last on English soil were interrupted by the deafening roar as the four Rolls Royce aeroplane engines provided the reversed thrust to slow the big plane down. As the jet came to rest a new sound became apparent. The wailing of a siren preceded the appearance of the ambulance, blue light flashing, as it manoeuvred at the foot of the forward steps of the aircraft. The men in blue, with their red blankets and collapsible casualty chair ran up the steps and into the plane.

The likelihood of a doctor being a passenger in an aircraft during a medical emergency in the air may be as high as 90 per cent. There is at least a 50 per cent chance of a doctor being on board.[1] The question in my mind at this time was whether perhaps on this occasion my grandfather might himself be that medical emergency.

But no; a gleaming white full length leg plaster appeared at the cabin door, to which was attached proximally a grinning tanned young holidaymaker. My grandfather, with his eccentric wisps of silver hair almost touching his shoulders appeared next, also grinning. I reflected that my family has an uncanny knack for being in on the action more often than not. Customs formalities were all but waived for the invalid and the 'Professor' of Medicine—drama always manages to inflate status. Then my grandfather and I were united, this time on English soil, this time in the land of *my* medical teaching and medical practice.

'You look pale my boy. You should come to practise in the sun. And before you say anything you will call me Bertie. I don't feel like a grandfather and certainly don't wish to be addressed as one.'

So began Bertie's seven day sojourn and evanescent experience of general practice in the Jet Age.

Since leaving England to retire to the sun my grandfather's experience of medicine had been confined to his work as medical antiquarian and archivist for his island's medical society's library and museum. No doubt he could teach me a thing or two about medicine in the Dark Ages—but what of his knowledge and opinion of current practice?

The jubilant receptionist

Our first Jet Age incident occurred bright and early on the Monday morning. Bertie had insisted on accompanying me right from the start of his visit. After all, he said, how else could one report back to the medical society the wonders of contemporary British medicine.

We found our senior receptionist in a jubilant mood—a fairly uncommon thing for a Monday morning. She had just received official notification from the local health authority that she had been appointed to her own job! Great joy. Congratulations. We all knew she could do it. Bertie was visibly perplexed; I was bemused. An explanation had to be given: but where to start?

Bertie had left the UK just around the time of the beginnings of the NHS as we know it today. Yes, he knew the basic structure. Well then, I said, it should be simple to appreciate that one complete tier of the Health Service administration had recently been abolished in an effort to rationalize and simplify the structure. Quite simply, with the disappearance of Area Health Authorities, the districts would obtain more autonomy and would undertake some of the functions at a more local level that the old Areas used to cope with. In doing so there had to be some rationalization between the outgoing Area and the four Devon District Health Authorities. And so it was that our senior receptionist, who had previously enjoyed the status of a higher clerical officer in our health centre, had been 'slotted-in' to her own post! Thus, concluded the letter from the sector administrator (community) 'I am relieved as no doubt you are, that we have completed this exercise, and I look forward to working with you under our new arrangements.'

Leaving our senior receptionist in her reverie and ecstasy over her new old job I spent some time before starting surgery detailing the current structure of the NHS, and in particular the way in which general practitioners as independent contractors are able to make their living in the English health care jungle. I finished this introduction to contemporary general practice with a flip through the Red Book. Clutching this leviathan of obfuscation to his breast, and muttering something in Latin, Bertie accompanied me into the consulting suite and we began morning surgery as the church clock began to strike nine.

It was obvious from the very start that I was onto a winner. Whereas the medical student of two weeks ago had received courteous deference, my grandfather was accorded great respect. He listened to the patients' stories with great concentration and it became something of a repetitive task to re-engage each patient and encourage them to swivel back towards the greenhorn of the pair of physicians they had been confronted with. After the usual mixture of Monday morning ills, Bertie and I settled into a relaxed format of joint consultations; each patient interspersed with the sort of clinical banter that one might expect between the professor and his student; and more often than not being preceded by 'Now in my day . . .'.

Before the end of the morning the 20th century had started to rear its complex technological head and the last two patients had Bertie sitting back in his chair in a state of shock. Both had carcinoma; the first a lifelong smoker with terminal carcinoma of the lung who was being managed on

an outpatient basis by the local chest physician. He was complaining of dyspnoea and was obviously distressed. His left hemithorax was dull to percussion with totally absent breath sounds and his mediastinum was shifted well over to the right. This patient had been bronchoscoped five weeks previously. At this time nothing had been seen but he had deteriorated rapidly since then. Some two weeks ago over seven litres of effusion had been drained, a pleural biopsy had been taken and cytotoxic drugs had been instilled into his pleural space. He was now obviously in trouble again. Our office staff arranged transport to hospital while I spoke to the house physician and he was transferred to the chest unit immediately. Bertie wanted to know what they could possibly do for this man 25 years his junior. I explained that he would probably have his effusion drained again and that although this would undoubtedly recur over the following 24 to 28 hours, the relief of dyspnoea obtained thereby would last much longer.

The next patient was a retired airforce officer with a ceramic hip prosthesis and disseminated adenocarcinoma of the bowel. He had just returned from a holiday in the Carribean and was about to begin pulsed chemotherapy. The purpose of this visit to the surgery was to obtain further supplies of dressings and appliances for his stoma. As I wrote the prescription I detailed the items: adhesive paste, Karaya gum rings, stoma bags, aerosol personal deodorant and some adhesive squares to cover the stoma whilst swimming. We discussed this patient whose illness had begun six months previously with rectal bleeding and dyspepsia.

I explained that the patient himself had ascribed his problems at that time to the nonsteroidal anti-inflammatory drugs that he had taken because of painful arthritis in his non prosthetic hip. There had soon followed a massive haemorrhage and following transfusion a colonoscopy had revealed a tumour at the splenic flexure. I was able to show Bertie some colour slides of endoscopy of both the proximal and distal bowel. That the tumour should have been histologically typed before knife was put to skin impressed him greatly. I explained further that at laparotomy the tumour had been resected, staged as a Dukes Grade C and a defunctioning colostomy had been fashioned. Following later routine closure of the colostomy the patient had developed a sub phrenic abscess the confirmation of which was provided by abdominal ultrasound. He subsequently obstructed and developed Gram Negative Shock for which he received intravenous broad spectrum cephalosporins, tobramycin and metronidazole. Because his weight had fallen from over 85 Kgs to around 55 Kgs he was started on total parenteral feeding on which he slowly recovered only to find that his tumour had disseminated. There was enough in the history of this man to keep Bertie and me occupied in debate and thought for much of the rest of the day.

After the air commodore had left us with his shopping list of stoma care appliances I reiterated one of the maxims of my professor of surgery at my old medical school. There are three hidden tumours which are really worth looking for, he had taught me. The first is bowel tumour because resection *can* result in cure: the second is kidney, because removal of even advanced renal carcinoma may result in regression of secondaries: the third is carcinoma of the breast, because mastectomy with or without subsequent radiotherapy and chemotherapy avoids the unbelievable horror of a fungating tumour.

As we left the surgery to do the visits I summarized two other recent cases of treated carcinoma with excellent prognosis. One was a testicular tumour and the other a malignant melanoma which had been picked up very early. I briefly went over the various protocols that I had personally seen used in the treatment of such diseases as childhood leukaemias, Hodgkin's disease and myelomatosis. We discussed the role of the contemporary general practitioner in relationship to prevention through screening. I could see that grandfather was impressed, but at the same time quite astounded by the costs of current health care.

House calls

Our three visits after morning surgery were all fairly local despite our large practice area. Interestingly, two of them had renal problems.

The first was a 76 year old retired farmer who had presented during the winter months with pneumonia. Routine urine testing had confirmed symptomless haematuria. Intravenous urography had confirmed a non functioning left kidney and subsequent abdominal ultrasound had shown a large renal mass. Surgery had been difficult with tumour adherent to spleen and also growing into the inferior vena cava. An isotope liver scan had confirmed small hepatic secondaries and a CAT scan of his brain was negative. His discharge medication comprised no fewer than a dozen drugs: digoxin to control his fast atrial fibrillation, a high ceiling loop diuretic to control heart failure, sustained action theophylline for bronchospasm, a progesterone to mitigate renal secondaries, iron because of microcytic anaemia, vitamin C, domperidone because of nausea, a deflatulent antacid, chlorpromazine because of unremitting hiccoughs, a stool softener, an evacuant and a suspension of nonsteroidal anti-inflammatory drugs for arthritic pain. Bertie was speechless. All this for someone over his three score and ten years. If such efforts were made for the elderly what of children? Patience my dear Bertie, all would be revealed as the tapestry of general practice in the Jet Age was unfolded.

We left our retired farmer and his newly qualified 'pharmacist' wife with a promise that each week we would remove one preparation from the medicine cupboard so

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that by the summertime he would be on minimum but effective treatment.

Our next call was to a young woman who was in the local home dialysis programme. As we entered Tina's portacabin with its miniature personalized renal unit Bertie could hardly stand without support. As we threaded our way carefully to the head of the bed Tina's mother greeted us.

'Oh doctor it's you, we thought it might be the home dialysis technician; there is something wrong with the 'mouse' and one of the artery clamps has fallen into the back of the machine!'

I must confess to having a soft spot for Tina: with a strong family history of hypertension she too had developed fulminating hypertension which had defied treatment and progressed to end stage renal failure. She and her parents had coped with the arduous and mentally exhausting dialysis training and the whole family now took the whole complex technical panoply on as though it were just another kitchen gadget.

Outside, her mother confided, 'She nearly had a kidney at the weekend. The people from the donor computer in Bristol telephoned to put us on standby, but in the end they had a better match in France and they only had the one kidney.'

'There will be another, I am sure; besides, you might as well get your money's worth out of all this,' I said, pointing back towards the portacabin.

As we drove home to lunch, I postulated that the new seat belt legislation recently promulgated might mean that Tina has a rather long time to wait for a donor kidney.

I do not know how the subject came up, but once again my old professor of surgery at Manchester managed to spoil our lunch when Bertie spotted an article in a recent British Medical Journal in which the technique of intestinal anastomosis using magnets was described.[2] In the same issue and on the opposite page was an article describing the use of laser photocoagulation of senile macular degeneration.[3]

I introduced Bertie to my high fibre diet and preference for whole foods and we agreed that the high level of refinement in foods today was not one of the advantages of advanced civilized societies. There followed a somewhat unsavoury commentary on the expense of treating constipation with drugs and other prescribable diet aids when all that was really necessary was a modification of basic diet and life style.

Our visit after lunch was a routine postnatal call on a young mother, recently delivered of her third child, a healthy girl, by elective caesarean section. Bertie wanted to know whether I still carried any of the equipment out of his 'Midder' Bag. I admitted that I still had the bag, with its axis traction forceps and equipment for inhalational anaesthesia; but that the likelihood of my using it was very remote indeed. My summary of the pattern of modern antenatal care and subsequent paediatric surveillance obviously impressed him; especially the bit about perinatal mortality having fallen to below ten per thousand at our Plymouth District General Hospital. 'Yes, yes, yes,' agreed Bertie, 'but you have never experienced the pure joy of delivering a baby at home, have you . . .?'

At this point I managed to get him off the track of home deliveries by offering him a visit to the local special care baby unit—a visit I shall describe in my next report of general practice in the Jet Age.

References

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ASPECTS OF PRACTICE

Ancillary staff for summarizing records

RICHARD BAKER

General Practitioner, Cheltenham

The Joint Committee on Postgraduate Training for general practice has laid down as a guideline that in training practices all medical records should contain notes arranged in chronological order. Dr Baker describes how his practice tackled the next step—to complete a comprehensive typed summary for each patient's record.

ANYONE not acquainted with the history of general practice records would have been astonished to learn that training practices have had to be told to keep their records tagged in chronological order. Surely those practices selected for the job of teaching should have records that would be an example to the rest of us. The reasons for this state of affairs is not hard to find. The 10,500 files in our own practice have been handed down to us from previous generations of doctors in a totally disorganized jumble. To bring order to this chaos seemed at first a task too large to be accomplished.

Our initial attack on the problem was for each doctor to cull, file correctly and construct a comprehensive typed summary for each of five sets of notes each week. After completing 548 records, we gave up. It had become obvious that we would never manage to summarize most, let alone all of our records, and we concluded that it was impossible for a busy practice to summarize all its records unaided.

Method

The alternatives were to settle for skeleton summaries only, or to employ someone to make full summaries for us. Previous reports gave us conflicting advice. Tomson summarized 90 per cent of his notes himself in six years. Stott summarized in three years at a cost of £2 for each folder and