GENERATIONS OF PRACTICE

General practice in the Jet Age—II

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In this second article, Dr John Challenor continues his account of his grandfather's introduction to general practice in the Jet Age. He describes their visit to the local special care baby unit.

OUR special care baby unit was the one in which I had cut my neonatal medicine teeth; it was as busy as ever. Five babies on ventilators: a pair of twins delivered at 26 weeks gestation; two babies at 32 and 33 weeks with respiratory distress syndrome and one with a diaphragmatic hernia awaiting transport to the paediatric surgeons at the Regional Centre in Bristol.

'This one,' said Bertie, pointing to a tiny wizened piece of brown flesh lying under the phototherapy lamp, intubated and with two arterial lines and a long venous line for parenteral feeding. 'How much does he weigh?'

The Sister in charge looked at the chart. 'He has just reached 800 grams . . . he'll be joining Weight Watchers soon if he goes on like this!'

'Will he survive?' asked Bertie.

A difficult question to answer I thought; if he does not open up his ductus arteriosus; if he doesn't get an infection; if he doesn't develop a pneumothorax (or two); if he doesn't have a ventricular haemorrhage; if he doesn't get necrotizing enterocolitis; if if if . . . The nurse interrupted 'Yes, he'll survive for sure.'

'But what will he be like?' asked Bertie.

'He'll be alive.'

'But what about his brain?'

'We expect it will grow with the rest of him.'

My turn to interrupt: 'Well Bertie, the ones that do well, do well; I have seen them come up to the surgery with their coughs and colds as toddlers and they are as bright as buttons and you cannot tell that they were born before the third trimester.'

Our child development clinic

The following afternoon Bertie joined me in our child development clinic. This produced a feeding problem at six weeks, a mother worried about her child who had a mild talipes and a four year old child with quite a pronounced genu valgum.

Teat sizes and feeds were discussed with the first. The second was shown how to perform simple corrective physiotherapy, and the third child had his intermalleolar distances measured and was promised a follow up in six months. While all this was going on the health visitor had seen half a dozen more children and parents for an assortment of problems.

I reiterated my enthusiasm for these paediatric surveillance clinics. For the general practitioner they are the cream on the milk of good paediatric care. For our practice they have a dual function. They serve to endorse family care and are an additional safety net for paediatric problems that *might be seen too late in the normal course of events.*

The following day brought us back to Jet Age general practice. A university student in his first year came up to surgery stating that he had felt unwell following his return from West Africa 48 hours earlier. His symptoms were nausea, anorexia, and aches and pains all over. Bertie's eyes lit up and his look said 'Sort that one out!'

The patient volunteered that he had been in contact with hepatitis two weeks previously. Certainly his symptoms would fit, but the incubation period for even viral type A hepatitis would be much longer than this.

All sorts of exotic possibilities flashed through my mind and I mumbled something about Marburg virus and Lassa fever as I examined the patient. This confirmed a low grade fever, an injected pharynx, axillary lymphadenopathy, a tender liver and palpable spleen. This would certainly do for hepatitis so I took blood for hepatitis antigens, liver function tests and a full blood count with a differential screen. All the specimens were labelled with the local pathology department warning 'danger of infection' and the courier picked them up at 13.00 to take them to the various departments for analysis.

'Sometimes, Bertie, I can get a full blood count and plasma viscosity before I have read the ESR!'

We discussed this interesting problem for the rest of the day. The following morning the same patient appeared in the surgery again, this time complaining of a sore throat. Examination confirmed a florid exudative tonsillitis. A swab was taken and he was given an intramuscular injection of one million units of benzyl penicillin followed by oral penicillin V. After lunch the results of the liver function tests were phoned through and these confirmed a picture of hepatitis.

The following day both the full blood count and the microbiology results confirmed not viral hepatitis, not serum hepatitis, but glandular fever! At about the same time, the patient telephoned the surgery to say that he felt much better thanks to the antibiotics and would we mind if he cancelled the follow up appointment as he had been asked to go sailing. Somewhere in this there is a moral.

The star of the antenatal clinic that week was undoubtedly our local midwife who had borrowed a Sonicaid for a particularly apprehensive young mother-to-be. At 14 weeks the fetal heart rate came through clearly and once again Bertie's eyes were alight with the wonder of it all.

More official correspondence

The end of Bertie's week in general practice began in almost the same vein as it had started. Our practice received in Friday morning's mail the detailed conclusions of the much publicized Clothier Report.[1] As we are a rural dispensing practice the implications of this report which had followed a longstanding debate was important to us and I explained the various main points with respect to dispensing arrangements in rural areas. I handed the memorandum to Bertie who flipped through it, and then, with his spectacles balanced at the end of his nose and in a particularly official voice read:

'Section 11 Paragraph 5. The RDC will give formal notice of the appeal or application, and of its eventual decision, to the FPC, LMC, LPC and any doctor or pharmacist whom the FPC had informed on its decision on rurality. The FPC, the LMC and the LPC will have 30 days from the date on which notification of the appeal or application was sent to them in which to submit representations to the RDC. The RDC will determine the appeal or application in whatever manner it thinks fit and its determination will be final; there is no right of appeal to the Secretary of State on rurality. Any area which the RDC determines on appeal to be rural in character will be a controlled locality and any area which it determines not to be rural in character will not be, or will cease to be, a controlled locality.'

Well, that couldn't be clearer . . . could it?

Homeward bound

As I drove my grandfather back to the airport I saw that he held in his hand his notepad. Throughout the week he had from time to time written with his meticulous hand some detail or other. As we drove, he looked at the cover and leafed through the pages.

'You know, Grandfather, what you have seen this week is just a small part of Jet Age general practice. Certainly we need to know about the sophisticated investigations and treatment techniques so that we can provide the best for our patients. But general practice is more about people and their people than all the science in the world. I like to think that we keep modern techniques and procedures in perspective. Science does have its place but it has to stay in the traditional triad of history, examination and special tests. That has not changed in your lifetime and I do not think that it will change in mine.'

And so it was that my grandfather gave his presidential address to the island medical society of his home. The title was 'General practice in the Jet Age' (or 'History, examination and special tests'). Curiously, the title in parentheses was the title of his doctorate thesis in 1922, and no one had heard of jets then.

Reference

1. *The NHS (General Medical and Pharmaceutical Services)* 1983. Amendment regulations. Statutory instrument no. 313.

CONTROVERSY

Fluoridation update

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In the past, the fluoridation debate has been noted more for its tremendous emotionalism than for its scientific accuracy and objectivity. Recently however, fluoridation enthusiasts are hearing a new attack on their long-held position by reputable scientists who have raised a number of important questions which have been published in some highly respected journals.[1]

FORTY years ago it must have seemed a superbly simple idea. Just add a small amount of a cheap chemical called fluoride to a community water supply and Hey Presto! A costly and ubiquitous disease, tooth decay, is controlled and perhaps in time even eradicated.

Recent research however has shown that tooth decay amongst children has declined dramatically in the last ten years even in areas with almost no fluoride in the drinking water.[2] The differences between rates of tooth decay in areas with different fluoride levels in the drinking water are now very small and almost insignificant. Thus the usefulness of water fluoridation must be evaluated in light of this new research. Additionally, individuals are increasingly exposed to fluorides in processed foods and beverages, dental health products and medicines as well as insecticide, pesticide and fertilizer residues; and, because of growing industrial pollution of the atmosphere with fluoride emissions, even the air they breathe.

Fluoride toxicity

Fluoride can be harmful; and with so many possible sources of fluoride ingestion the risk of overdosage is obviously real. Moreover, recent reviews of the subject suggest that fluoride toxicity may have been underestimated.[3]

Two questions are being raised in the medical and dental literature with increasing regularity:

1. Are some individuals now ingesting too much fluoride from a growing number of everyday sources?
2. At what concentrations in the body can fluoride damage enzyme systems, cells and organs?

A considerable research effort is now underway worldwide, in an attempt to answer these questions. Meanwhile, many knowledgeable scientists no longer believe that water fluoridation will lead to major improvements in dental health in areas where use of fluoridated toothpaste is prevalent, and where dental health care is readily available.

The margin between an apparently safe, and a harmful dose of fluoride is impressively small. Therefore the notion that if a little fluoride is good then more must be better is not only wrong but dangerous. The tendency to search for more and more ways of increasing exposure to fluoride should be discouraged.[4] Indeed, the ten members of the Quebec Government Committee of Inquiry into Fluoridation stated in 1979 that there has been 'a substantial increase in fluorides in water, in food and in the atmosphere. In the circumstances, the Committee is of the opinion that an additional amount of fluoride would be not only useless