and easy to clean too. No flooring except hardened steel stands up to stiletto heels, and the sooner they disappear the better for our pockets.

Lighting is very important to us and we must aim to get the right volume or number of lumens in each room. At the present time I am in touch with the National Physical Laboratory to find an answer to this. So far they have made it clear that one can only achieve this by use of the fluorescent tube to give the volume, aided by a tungsten lamp to supply the red of the spectrum, the missing element in fluorescent lighting. By this means one can achieve reproduction of daylight.

Sound proofing is very difficult to achieve. Lobbies sealing off the consulting room and examination room from the waiting room are the best method but add to the expense of building and make for much more time being spent in moving from room to room. A 4½ins. brick wall is required to ensure that sound is not transmitted through it. If an opening is made, either a door or window, then sound slips through easily. Double doors help but the space between needs to be at least 6 ins. Sound is transmitted by air and it is the air around door jambs and other openings which makes it so difficult to ensure good sound proofing. It is very much easier to scramble sound, and where one only requires to prevent a conversation being overheard, low background noises are quite effective. A long playing tape is most useful for this purpose and carefully chosen music should have the effect of relaxing the patients listening to it.

I have not attempted here to design the premises, only to give a broad outline of some of the facts which we require to know before commissioning an architect to produce a design. Up to date we have not attempted to design premises, only to arm the doctor with knowledge of the factors affecting planning so that he and his chosen architect can produce premises in which he can work efficiently and with comfort both to himself and his patients.

THE CONTRIBUTION OF DOCTORS' WIVES TO GENERAL PRACTICE

AGNES T. KENNIE, M.D., F.R.F.P.S.G.
Paignton

Most of my professional life has been spent in single-handed general practice. Being unmarried, I have often found the "domestic" organization of the practice as difficult as the profes-

sional work and I have had many occasions to envy my colleagues the support and assistance they obtain from their wives. Over the years I have heard the views of many of these ladies, my personal friends, erst-while colleagues and wives of members I have met at social gatherings of the College, and British Medical Association. This Research Fellowship* gave me an opportunity to talk to many others. The part they play in the practice varies considerably. Some know more than the doctor himself about the organization of the practice. Some have certain duties only. Others regard it as their prime concern to keep away from the practice so that in his home the doctor can forget his work and find relaxation. Many would not profess themselves interested in practices and general practitioners but most are deeply committed and highly knowledgeable of all that pertains to the running of one practice—and one doctor. They can, but with more reluctance than their husbands, be persuaded to " talk shop ". The reluctance is due partly to training which instils the doctrine that members of a doctor's household " see all and tell nothing ". It is also the result of a defence mechanism to " talking shop ", built up over long years of suffering it from their husbands. Frequently, also, they feel that their contribution is personal and confidential and less suitable for exchange of opinion than the scientific and political interests which so fire their husbands in debate.

For these reasons it seemed imperative that to meet and talk with these ladies in different parts of the country I had to have some sort of introduction. Any question of random sampling was out.

Collecting the Evidence

The aim was to cover as wide an area as possible in the time at my disposal and to include different types of practice. As a first step, I noted on the map areas where I had friends or colleagues. Then I asked officials of the College and British Medical Association to suggest in other areas any ladies who might be willing to receive me. The final list was made up of 12 personal contacts, 16 from College introductions, 11 from the British Medical Association and in two cases I had no introduction other than fellow membership of the College. Of the 41 visits made, 24 were to wives of College members. (Table I.)

An enormous amount of time seemed to be taken up with planning and correspondence. Although I had met only six of these ladies on a previous occasion I was received everywhere with the greatest courtesy and co-operation. Occasionally there were initial suspicions but these usually dissolved when it was appreciated first,

*The work described in this paper was carried out whilst holding an Upjohn Travelling Fellowship.

that I did not come from the Ministry and second, that I was not writing a book. Doubts were conclusively dispelled when it was realized that I had a home and practice to run myself and a real interest in both domestic and professional organization.

TABLE I

THE CONTACTS

Source of introduction	*Member of College*	*Non-member*
Friend, or introduction by colleague	2	10
B.M.A.	4	7
College	18	—
	24	17

The Questionnaire

A list of questions was prepared before the project began. A good deal of time and thought had been given to them and they had been grouped so that filing would be easier if the study increased. In practice the questionnaire was not always completed. If the time was short, there were interruptions, or the occasion seemed inappropriate then as much ground as possible was covered in the chat with the wife or doctor and wife. Frequently the conversation went off on an interesting tangent and the questions were forgotten but the exchange of ideas on these " side-lines " was well worth the loss of the other information. Usually, by the end of the interview, innumerable topics of mutual interest had been found and it was hard to tear off to the next contact perhaps 100 miles ahead. The best and most informative meetings were those which finished informally round the fire with a completely frank exchange of opinions.

Types of Practices Visited

Greater London and 16 counties were visited. Some day I hope to visit the " blank " areas on my map. Large cities, industrial towns, market towns, villages of a few hundred souls and one health centre were all included and showed, despite the chance method of selection, a fairly wide spread of different types of practice. (Tables II and III.)

Thirty-one proved to be almost entirely N.H.S. practices. Sometimes I asked the doctor if he could give me a rough idea of the size of his private practice. Three said they could tell me "exactly". One said 20, another 10 and another 6 patients. In three there was an appreciable amount of private work and in seven it was a major

source of income. None was entirely private. Two doctors said they refused to take private patients; one because it suggested two types of service and the other because in a rural area, with mileage and other inducements, there was no financial advantage in having the odd private patient. Ten were in single-handed practice and the rest in partnerships of two or more. (Table IV.)

TABLE II
PRACTICES IN THE COUNTIES VISITED

Ayrshire	2	Lancashire	1
Cambridgeshire	1	London	2
Cornwall	1	Somerset	1
Cumberland	1	Surrey	3
Devon	9	Warwickshire	2
Dorset	2	Westmorland	1
Dumfriesshire	1	Wigtownshire	3
Hampshire	4	Yorkshire	3
Kent	4		

TABLE III
POPULATIONS IN AREAS VISITED

Over 1,000,000	4	10,000 to 20,000	6
500,000 to 1,000,000	0	5,000 to 10,000	1
200,000 to 500,000	4	1,000 to 5,000	6
100,000 to 200,000	1	500 to 1,000	0
50,000 to 100,000	7	Less than 500	1
20,000 to 50,000	11	Total	41

TABLE IV
TYPE OF PRACTICE

Almost entirely N.H.S.	31	Entirely rural	4	Single	10
Also some private practice	3	Entirely urban	21	Two partners	11
Also large private practice	7	Mixed	16	Three partners	7
				More than 3 partners	13
	41		41		41

An attempt to classify the practices by the age of the doctor was not so easy. (I avoided the obvious pitfall of considering the age of the ladies.) Sometimes I knew his age, sometimes it was volunteered in the conversation, otherwise I employed the usual devices of information from friends and/or year of graduation. (Table V.)

TABLE V

THE DOCTORS AND THEIR FAMILIES
(38 families)

Doctors		*Children*	
Age: Under 30	1	Under school age	28
30s	13	School age	49
40s	14	School to 21	8
50s	9	Over 21	13
60s and over	4		
	41		98

It will be seen that the majority were in the active period of working life with heavy family responsibilities.

The Wife's Contribution

Defining the role the wives played in their practices was difficult. Occasionally I was quickly put in the picture as on one occasion when, the wife being called away, the doctor said in a stage whisper, " to tell you the truth I couldn't run the practice without her, but for goodness sake don't tell her so ". In this and other homes it was obvious that " building up the practice " was a husband-and-wife affair, the wife seeking to meet the patients, help in the surgery, answer the telephone calls, and know particularly the mothers and children of the practice. Some of these ladies were trained nurses but others had no previous experience and admitted they " had had to learn a lot since they married ". Individual inclination rather than geographical position was responsible for this approach for it was seen in large cities, in suburbs and also in a very rural community. Others were actively engaged in looking after the surgery, answering the telephone and door bells and generally supervizing, but kept in the background, holding desperately to what little privacy they could enjoy. Many, who had been what they called " through the mill " in their earlier days, prized above all the fruits of success, the immunity they now enjoyed in a home separate from the surgery. Doctors as well as wives often voted as top priority for the future some private life away from the practice. On the other hand, those who had achieved already a separate

surgery spoke of the heavy expense involved in employing ancillary help to cover all that the wife had at one time undertaken. But even the most elaborate staffing arrangements did not give the wife complete independence from her husband's work. In one well organized practice where there were as many ancillary helpers as partners, the lady I met said rather ruefully that she was kept busy most of the year deputizing for one or other absentee member of the staff. Yet she was one of the ladies who described herself to me originally as " not a proper doctor's wife ", a term which usually caused some amusement but which I heard more than once from those who led some semblance of private life. It would appear that there lingers a precedent, respected even by the most emancipated, that in general practice a wife is committed to her husband's work.

The telephone. Whatever else they do, few wives escape the tentacles of their chief enemy, the telephone. To most doctors it is a tiresome (or worse) part of their daily lives; but for the wives it can be both a fetter binding her to the house and a summons which calls her man away from it just when she hopes he will rest or that she can have something of his company. Even those with separate surgeries were often on duty at lunch time, in the evenings, and at night when the " full time " staff was off duty. Others were tied to it almost 24 hours per day. One young mother said that her children had survived only because she had become expert at propping the baby on the breast with one hand and using the other to answer the clamourings of the telephone. Generally there was a good deal of feeling about patients who phoned to " catch the doctor " and talk to him at his all-too-short meal times. In one industrial area it was not uncommon for shift workers who came off at 6 a.m. to phone then " because it was more convenient ". All agreed that it was the small minority of thoughtless people who strained the relations for all. Two few realized just how difficult a day could be in a doctor's home; but one doctor's wife admitted that when she was tired and exasperated with the phone it was " usually the wrong patient " who suffered the result of her annoyance. All spoke of the thoughtful patients who co-operated and appreciated the doctor so much that they often held back. They suffered because of the selfishness of the few. Several described their practice as made up of delightful people and others spoke of the kindness shown from unexpected quarters to the doctor and his family.

Methods of dealing with the telephone messages varied considerably. Some wives were emphatic that they simply took the message as received and passed it on to the doctor leaving the interpretation to him. Others considered it essential to know something of the

illness especially when a visit was received out of the usual hours. Only then could the more urgent cases be seen first, the doctor sent out with any special equipment necessary, his time used to its best advantage, and frivolous calls discouraged.

Many were well aware that their efforts to save the doctor's time were misunderstood by some patients. They thought the public appreciated that a secretary had a right to help save the doctor's time and energy but suspected that a wife was hiding him away somewhere. One said that when she felt she had to be particularly firm she pretended she was the secretary. On the other hand the lord and master was more likely to grumble at his wife than his secretary if she involved him in unnecessary work with some troublesome patient. The last straw was when that patient phoned to say how " sweet " the doctor had been. " Behaving like Dr Jekyll and Mr Hyde " said one exasperated wife. But a doctor listening in to similar home-truths cheerfully commented that a " good blowing up every now and then was one of the occupational hazards of being a doctor's wife ".

Guarding his off duty time. In a number of practices it appeared that the wife acted as a kind of preliminary filter for telephone messages, taking them even when the doctor was at home. (One practitioner said he made a point of never speaking on the phone, but he never refused a visit.) She was often his defence when he was off duty. Sometimes there were difficult situations when a partner (or his wife) were not co-operative or when the patient would not accept the deputy. This might mean that husband and wife could not go out together.

Many plans had been devised to obtain a period of freedom for them both; external telephone extension to colleagues, consulting room switchboard to partners operated by a caretaker, telephone diversion arrangements at the exchange, alternative numbers listed in the telephone book " if no reply ", automatic answering devices and arrangements for " telephone sitters " in the home. In one practice an external extension had been arranged to the home of an invalid confined to her room. It had been a great help to the doctor and his wife and a new interest and incentive to the patient. Diverting the practice calls usually meant being deprived of private calls also, so some paid additional rentals for private "ex-directory " numbers and others had " by-pass" numbers. But many regarded it as of prime importance that the diversion arrangements be watertight and " private calls could wait or find another way in if they were important ". In partnerships there was often a " surgery " number always manned by a partner or a member of the staff and partners might or might not have their individual

numbers in the directory. Two doctors had gone into partnership " more on account of telephone difficulties than for any medical reason ". Where no telephone diversion system was possible, or partners or colleagues did not co-operate, then husband and wife could not be out together if house and phone were not attended in their off duty time. In one practice this was so difficult that they had given up trying to make suitable arrangements and the wife had her own off duty day, different from her husband's. In two others, the wives confessed themselves so resigned to being constantly tied that they had taken up hobbies which they could pursue at home.

" *Manning* " *the house.* " Covering the telephone ", even by these complicated and expensive arrangements, was not always sufficient in areas where patients were accustomed to call at the door rather than 'phone. Then it meant that the wife had to " stand guard " if the doctor was off duty but at home. The majroity of patients did not intrude, but there were some who thought nothing of seeking him out in his garden or workshop. One wife said she " could stand it all except when patients walked into her kitchen to deliver bottles of urine ". This couple lived on a housing estate. When their children were young, they would have preferred to spend their half days in the garden, but they had been obliged to erect a fence so that they could hide the car behind it and then retire into the house to pretend they were away from home. An older couple loved their beautiful garden but said they were often obliged to leave it on their half day to get any peace.

This necessity to " get away from it " seems to account for the hobbies and holidays chosen by the doctor. Sailing was the escape route enjoyed by the greatest number. One wife said that " sailing and the weekend rota had opened up a new life " for her husband. As close seconds came golf and music. Others were photography, hill climbing, and " any manual labour " (which included gardening). Of holidays, most said their ideal was " enjoying the family " or " finding the sun " and those who had not found a boat in which to sail away from the telephone " found the answer " in a caravan, a cottage in the country, or fishing in the Highlands.

Many of these doctors did postgraduate work, or sat on medical and other committees and some admitted that these had to take the place of hobbies. A number of wives were concerned that these activities took up more and more of the doctor's time and they were anxious about the effect on his health.

Off duty arrangements. Off duty arrangements were obviously as important to the wife as to the doctor. They varied greatly and it was evident that many had been evolved in the last few years.

Where they were relatively new, the doctor and his wife who had struggled along on the " one man band " arrangement remained slightly intoxicated by their new-found freedom. All but five had evolved a rota system with partners or colleagues to share duties on half days and weekends, but some did their own midwifery. Sometimes evenings were also arranged by rota and in one practice the partners took a week at a time " on call " for evenings and night work.

Sometimes the senior partner did not participate in the rota but the wife of one said that she remembered so vividly her own troubles in the early days with the practice and a young family, that now she was glad to do more than her share to help the juniors who had babies.

Holidays. In most cases holidays could be taken together. They were covered by partner or assistant in 24, in ten by locums and in three by a combination of both arrangements. Having a locum meant the heaviest burden on the wives who had to make domestic arrangements for him in their absence.

Special difficulties arose where several partners had children of school age and wanted their holidays in the same month. Some had solved this happily in a rota of different months in successive years. Where there were three or more partners many had recently employed a locum to cover the holiday period, " otherwise the summer goes past with everyone doing extra work ". One doctor in a pleasant area said he had been appalled at the number of principals who had applied to do his locum *in lieu* of a holiday because of financial difficulties.

Cleaning the surgery. Six wives had to clean the surgery and waiting room personally. Many of the older ladies could remember days when a doctor's home was well staffed yet now only five had resident domestic help. Some spoke of the increasing difficulty of obtaining help in the face of the competition of industry and the irresponsibility of the public in serving a profession which it, in its turn, expected to function 24 hours per day. Yet many spoke in glowing and affectionate terms of trusted employees who identified themselves with the practice and were as unlikely as the doctor or his wife to " let the practice down ". These uncertainties of domestic help meant that the wife was called upon to fill many roles. It often made her life more unpredictable than the doctor's with his rota and other " cover " arrangements. In partnerships, or where there were branch surgeries, a caretaker was often given a flat in exchange for domestic and other duties at the surgery and on the whole this seemed to work well. Sometimes relatives were able to help and in one family it was the policy to train the children from their early teens to help and take a correct message on the telephone.

Secretarial work. Only six wives were actively concerned with the secretarial side of the practice, writing letters, filing reports, making N.H.S. returns, and so on. When they were, it often involved several hours of work each week. Many spoke of the great relief they experienced when the N.H.S. brought an end to sending accounts.

Life in a Doctor's Home

The wife. Is the life of a practitioner's wife really different from that of other wives? This produced an almost universal " yes ", although some said the clergyman's wife had similar problems. Many spoke of the isolation from normal social life both for themselves and their husbands. The telephone kept them at home when other wives were free in the afternoons. One confessed that although she might not want to go out, she always had the feeling that she couldn't. Often non-medical friends failed to realize that being " on call " meant making arrangements whether anything happened or not. In the evening it was difficult to find an intelligent person to take phone calls. Even then, the doctors work was not finished until after most social functions began. " I can never count on him, either being there on time or remaining with me all the evening " was a common remark. Many had long ago decided to refuse invitations unless the doctor was off duty. One commented how different their social life had been when he was in hospital work.

The children. But the difficulties of social life outside the home were not the chief concern. Many longed for a more normal domestic routine and some wondered if a doctor's home was a good place for children with constant interruptions, erratic meals, too much medical talk and the unpredictable hours of the father. Even if the children went away to school he was often unable to attend weekend functions like other parents. Others were equally emphatic that, provided the home was happy, the children came to no harm, and it was good for them to see service and responsibility accepted as normal parts of life. Meals need not be erratic except on rare occasions. On the whole the chief grumble was that they and their children saw too little of their husbands. This was one of the reasons why some preferred the combined surgery and home, for despite the other disadvantages, they did have a chance to see him occasionally as he dashed in and out.

In 38 families there were 98 children. Twenty eight were under school age. Of the 70 of school age or over, 17 were medical graduates or students or had these intentions. One mother said that she believed few sons of general practitioners were going in

for medicine and another that she would discourage her child from general practice although not necessarily from other medical work. Most parents said they would not try to influence their sons and daughters in the choice of a career and that in any case the children would make their own decisions. One commented that if a child chose general practice after all he had seen of it " then good luck to him " and admitted that she would also feel rather proud of him for doing so.

Their friends. Of the 30 who were asked the question, 24 said they knew most of the doctors in the area. There was a strong feeling that doctors talked too much shop on social occasions " and loved it ". The wives mostly disliked it, despite there being four medical graduates and 14 nurses amongst the ladies visited. One medical wife, in practice herself, " mixed her guests to stop this at all costs ". One said sadly that she had given up trying this and other devices for then her husband " just brooded all the evening " and that was worse.

Their colleagues. Thirteen of 26 said they had not been welcomed in any way by the profession when they had come to live in the area and they had felt very isolated at first. The official medical organizations held meetings " too infrequently and too formal " for new people to find friends. Others spoke warmly of the way their early days had been made happy by partners or colleagues. One young couple said that the social pace had been so fast that they had " found it quite a financial embarrassment " in their first years.

The National Health Service

Only ten had been in practice long enough to say if the coming of the National Health Service had brought major changes in their work. They had some very strong opinions. There were many grumbles about the Service. Usually when the doctor joined in, the comments became too political for this paper. One warned me not to let him loose on this subject. Another said it was responsible for making people so disease-conscious that " attending their doctor had become part of their lives ". They even seemed to think they had conferred a favour on their doctor if they hadn't seen him for some time. One wife said that her husband was so weary seeing trivialities that he " became quite animated when he had to deal with a real disease ".

In favour of the N.H.S. one spoke of the early anxious days of building up a practice under the old system; another of the doctor's satisfaction now in looking after a community rather than those who consulted him. From many the chief reaction was the expression

of relief at having no accounts to send out. " We were always worrying that the patients couldn't afford the bills " and " now we are able to see the poorer patients whose natural pride had kept them from seeking treatment because they couldn't afford it ". The husband usually commented on the amount of chronic illness which came to light in the first few years. Only two in 29 said that night calls had increased. Others thought they might even be less due to the " new wonder drugs ", or more numerous evening calls, or to patients now being seen earlier in an illness and having drugs prescribed against a possible emergency.

The wives seemed to think that there had been no real change in the attitude of the doctor to his calling which was " his relationship with the patient and not the State " and one said that her husband " had no patience with those who spoke of a breakdown in the doctor-patient relationship ".

Improvements for the Patient

Most thought that in the N.H.S. the patient had had " a very good deal ", but there were some suggestions for improvements. One thought chemist's shops should remain open as late as evening surgeries. Others were distressed to learn of mothers, with their babies of a few days old, being taken home from hospital in an ambulance with other patients. Several pressed the need for free drugs for private patients. The closer liaison of general practitioners and health visitors was discussed and interest expressed in the two practices and one health centre I visited where the health visitor was one of the team. When the husband joined in the discussion, his chief grumble on behalf of his patients was the length of the hospital waiting lists and the time patients were left undressed before being examined there. " The general practitioner just wouldn't get away with it ". Strong views were expressed about the autocratic attitude of some of the younger consultants and two practitioners had definite plans for his better education.

Appointment system. The appointment system was already operating in 11 of 39 practices and considered an advantage to both patient and doctor. Others were anxious to try it but had no receptionist. Sometimes the stumbling block was a place to accommodate her as much as her salary. The surgery hours in other practices had been so arranged that few patients needed to wait long enough to justify appointments. Almost all gave appointments to private patients.

Waiting rooms. Waiting room design obviously had claimed the attention of many in the last few years. One colleague, with a most attractive suite of rooms, laughingly admitted that after some women doctors in the town had redecorated their surgery there

had been a " wave of conversion " of premises. Heating, colour, comfortable seats, flowers, magazines, and toys for the children were found in many. One woman doctor said that the waiting room should be bright and clean but " not too fancy " for that increased the work when domestic help was difficult. No one complained of abuse of comforts by the patients. One wife said she saw none of the bad habits she had suffered when the waiting room was in her own home in the old days. She wondered if the change was due to better education or a higher standard of living. One doctor with problems of sound proofing had installed a radio which played softly in the waiting room. Nearly everyone found patients careless with magazines and many disappeared; " pinching magazines from a doctor's surgery is regarded as a normal practice ". But one said that occasionally other magazines appeared which he had not provided! Those who had spent a lot of money on their premises enjoyed the better working conditions and the appreciation and interest of some of their patients. But they were sore that they had to bear the financial burden themselves and the N.H.S. system of remuneration made no distinction between those who provided good premises and those who did not. The hardest knock of all came when, with the bills still rolling in, some patient commented on the improvements and added " the National Health Service must have done you well, doctor ".

Improvements for the Doctor

This feeling was echoed in the answers to the question " what changes in the N.H.S. would you advocate for the doctor? " All were directed at giving him more time to do his work properly without anxiety. Usually it was " larger capitation fees and smaller lists ", or " freedom from financial anxiety especially associated with the children's education ", or " financial encouragement for the doctor who improves his premises and organization ". The difficulty of obtaining locums, especially for sudden illness, worried the wives. One said she had seen her husband " age 20 years in the last 10 years " another that " all his energy was mopped up in his work ". Two wives, themselves practitioners, spoke of the high incidence of stress diseases in the profession but surprisingly the others did not mention these, believing that he was " blessed with remarkable staying power " and " looked after by a special providence " because he " took risks he would not tolerate in his patients ". One wife worried because he " drove the car far too fast, always trying to make up time ".

To the question " would you have him retire early " there were different replies. If the doctor were present he usually answered first if the answer was " yes "; " as soon as possible ", " can't

come too soon", "as early as financially possible but not much hope". Two young partners said they hadn't thought about their own retirement yet but certainly considered their seniors should retire early. On a more serious note they added that somehow or other it should be possible to ease the load for the older doctor. They were quite happy that merit awards should go for age and experience. If it were possible for a man to retire earlier he could be used to solve the great problem of locums. Some of the wives agreed with these sentiments and one said "there were masses of things they hoped to do before they were too old". Others were not so sure. One said her husband was "much too fond of his work to want to give it up"; another that she was most uncertain how he would face retirement as he had never had time to take up any hobbies. One couple in a delightful rural area said that for years they had looked forward to retirement and now, in their mid-fifties, they found themselves so fond of their patients that retirement was difficult to contemplate. But they admitted that having been shocked by the sudden deaths of two colleagues from coronary thrombosis they had "determined to take things easy before it was too late" and had cut their income by employing an assistant, installed labour saving devices in the home and so planned to give them both some freedom.

Separate house and surgery. On the future of good general practice most observations were concerned with the rota system, separate surgeries with ancillary help, and finance. On the value of the first there was almost universal agreement. It relieved the strain on them both and gave the doctor some freedom to pursue interests outside his profession. Most believed also in surgeries separate from the house but additional expense was involved and rents, capital outlay, and salaries often made the ideal impossible. Space could quickly become a problem to a young couple with a growing family and practice. Here those with the old type of house scored as they could plan rooms for assistant or secretary without much trouble. Others had to resort to new building or increasing intrusion on their private quarters. Those who preferred combined home and surgery (they specified separate entrances) felt they could help the husband more and watch that he had his meals properly. One wife-partner said it was more convenient as she was "able to keep an eye on the cooking between her patients". In new practices it was often thought desirable that the doctor be "on the spot" while building up the practice.

Improvements for the Doctor's Wife

Have you any suggestions to help the doctor's wife? This produced little immediate response. One friend said she "feared

she had been too much in a rut for years to have any ideas left ". Others said that anything which would help relieve the strain on the general practitioner would help his wife. One said that " just occasional recognition by the profession and those outside as a cog in the great wheel " would give her new heart. There were some who thought that probably the doctor's wife was the most neglected patient in the community and " could be nearly moribund " before anyone noticed she was ill.

Asked if they would be interested in some official organization for doctors' wives in the area there were mixed feelings. Some already knew and met their colleagues; some preferred their social life to be well away from medical circles; others thought it might be interesting; in a few areas it was geographically too difficult. In three centres visited, doctors' wives had already formed an organization for social and academic meetings.

Could the College and the British Medical Association do more for doctors' wives at postgraduate and other meetings? Some said they couldn't or wouldn't think of accompanying their husbands and some that the senior partner wouldn't let the juniors away. Others voted for a rest and " a good look at the shops " (especially when they lived in the country). A few liked to listen to the business part of the meeting if they were eligible to attend. Quite a number said that while they appreciated the social arrangements made for them, they would enjoy one serious session where they could discuss " problems of mutual interest with fellow travellers on this difficult road ". Ex-nurses said they would like to hear of new developments in the world of medicine, and some who had no training thought that they, too, would enjoy these. " I knew no medicine when I married but have jolly well had to learn some since " was a frequent sentiment. They had been obliged to take an interest on many subjects touching on general practice. Often wives were called upon to fill public positions and sit on committees as well as the more decorative roles of opening functions. Many refused because of home commitments or because they were shy. In rural areas the doctor's wife could have many demands upon her time. There was a consensus of opinion against judging baby shows where " one made more enemies than friends ". Many had been on the voluntary staff of the Family Planning Clinics from the early days when it had been difficult to interest other lay workers. One lady found this embarrassing when she met people socially and they said " I can't remember where I met you before "—she always hoped they wouldn't remember.

Much thought had been given to a number of important subjects. Some very strong opinions were held on education, sex-instruction, and television. Definite, and sometimes opposing views were held

on the relationship of medicine and religion. Indeed it was when discussing the more serious subjects that the ladies were most critical of our profession. They felt we often failed to give a lead, make a pronouncement, or come out in the open on matters of importance when the weight of our professional opinion could be of such help to the public.

Conclusion

In this paper I have attempted to describe the different types of practice and the contribution of those I was fortunate to meet. It cannot do justice to individual opinions. Although I visited many different kinds of general practice I became increasingly aware that I was " skimming the cream ". Those whom I had met at postgraduate meetings, or whom I knew because of their activities in the College or British Medical Association, or who had been willing to give their time to an unknown colleague, were people with ideas and ideals, often very strong opinions and a keen interest in good general practice. A large number gave many hours of their time to committee work of some kind, but I saw no evidence that this made them less assiduous in their practice, rather the reverse. Most wives approved or tolerated these extra duties, some lent their secretarial help, but others resented the intrusion on the husband's precious leisure.

Perhaps it was courting trouble to risk looking at the profession through the eyes of those who see us " behind the scenes " for, as one wife put it, the " chief job of a wife is to keep the doctor from becoming too swelled-headed ". Another said that some doctors kept their wives away from the practice " lest they should see his feet of clay ". But these remarks were both made in the husbands' presence. In their absence sentiments were different. They were perhaps best summed up by the husband who said that "for them marriage meant a sharing of everything" and it helped him enormously to discuss his work with his wife; and by the wife who wrote "to me a doctor's work is so important that I don't mind being a stooge behind the scenes ". Sometimes I took the further risk of asking the wife if she would " do it again " had she known all that it meant to be a general practitioner's wife. I quickly received the answer which I suppose such a silly question deserved; " one marries a man not a job" or "yes, for him, but not for anyone else".

We know that some consider it out of date to talk of the " family doctor ", he who tends the family in sickness and acts as adviser in all matters relating to living and dying. For us in practice it remains the ideal of what we should be. Outside the profession few appreciate that it involves also the doctor's family, whether they like it or not. This applies particularly to the doctor's wife. Many

have tried to define good general practice. After nine years the members of the College could not be said to be in agreement. It seems it will be longer still before anyone dares to define the ideal wife for the general practitioner. Most of us hope that a good deal of latitude will be left in both, the selection of the man for this calling and the choice he has of a wife.

Acknowledgements

I wish to thank the College for the award of an Upjohn Fellowship thus giving me the opportunity to do this work. Also the ladies who participated, and their husbands, for their help and kindness.

ANCILLARY HELP

J. A. S. FORMAN, M.A., M.B., B.CHIR.
Barnstaple

Discussing the advantages of having a nurse in the surgery team one day, an unconvinced general practitioner told me that he liked to do his own ear-syringing and bandaging. "It gives me time to talk to my patients", he said, "and so to know them. And it provides a restful moment in the day!"

Much as I like this particular practitioner, I find him blind. If I were asked "what is the chief stumbling block to better practice today?", I should unhesitatingly say—"lack of time". We need facilities—equipment, better training, better continuing education, and much else besides. But none of these will bear fruit if we have not time to use them. There is at present a widespread will to improve general practice. There is no lack of ability to achieve this improvement if the right conditions are forthcoming. But lack of time, and fatigue, continue to keep the standards lower than they need be.

A good many years ago, when I was new to general practice, and before I had the support of a nurse in the surgery, an elderly countryman, whom I knew slightly, came in at the end of a long evening surgery. I didn't make much of him. He looked ill-at-ease and was not communicative, but mentioned several unimpressive symptoms, and continued to sit at my desk as if waiting for something to happen. I had had a long and tedious surgery, including time-consuming procedures in the dressing room; more work was waiting outside; and the pressure was on. I looked over him on the couch and found nothing, became a little impatient, and sent him off with a request to come in again in a few days. But the look he gave me as he left the room, and the resigned way he said, "all right then doctor", stayed with me. He shot himself about six o'clock the next morning.

I have learned a good deal about endogenous depression since that night. But here is the point—this is the man that needs my time and yours; not our friends with wax in their ears again.

The administrative mind seems slow to appreciate the speed of