on an employment visa. It is not normally possible to convert from one type of visa to another after entering the country, and it is not possible to apply for immigrant status from inside the country having entered as a non-immigrant. It is important, therefore, to get things right from the start. If any kind of work is undertaken—even if payment is in the form only of accommodation or meals—an employment visa and work permit are required. Thus intending residents, research fellows, or locums all need employment visas.

If your preliminary contacts in Canada result in a job offer, you should ask the prospective employer to send you a more-than-usually detailed written job offer setting out precisely what the job entails and how your particular qualifications and abilities are appropriate. You should then take this letter to the Manpower and Immigration Section of the Canadian High Commission in London or to one of the Canadian consulates in several of the larger provincial cities and apply for an employment visa. Manpower and Immigration will seek evidence showing that the employer has made efforts to find a Canadian citizen or landed-immigrant to fill the position and that no such person is available. This requires communication between the prospective employer and his local office of Manpower and Immigration in Canada. If the job includes the clinical practice

of medicine, Manpower and Immigration also requires assurance from the appropriate Provincial College of Physicians and Surgeons that it will grant the applicant a restricted licence on its educational or other appropriate register. This may not be necessary for certain research positions not demanding practise as a physician. Finally, for resident positions in some provinces it is necessary to show that the provincial Ministry of Health approves the appointment of a non-Canadian. To get through this bureaucratic obstacle course requires patience and persistence and inevitably takes time. At least it gives ample opportunity to reconsider any hasty decisions. At a practical level you should plan well in advance allowing several months for all the official paper work to be completed. Don't lose heart at this stage.

I have tried to be realistic and, as a result, have been long-winded in setting out prospects for John and Jane in Canada today. If you have something to offer this country, then the country may give you an opportunity to work and learn and, above all, to enjoy the experience. Those Manpower and Immigration officials will not paint an unrealistically rosy picture so you will not be disappointed if the Minister of National Health and Welfare and the President of the CMA are not there to greet your flight at Toronto International.

Clinics in General Practice

A case of confusion and sciatica

M WHITFIELD, F DUDLEY HART

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The trainee's problem

The patient is one of a large family of Italians, most of whom work locally in the restaurant and café trade. She is now 48 and, like most of her family, excitable, emotional, and overweight. She and her sister married brothers, and have the same name, which is the beginning of the story because I have been guilty of getting the two sisters mixed in my mind. One of my first consultations in the practice was with the sister, who was recovering well from having an intervertebral disc removed.

When I saw the present patient five weeks ago with acute sciatica I assumed that she had had a postoperative relapse and sent her home to bed to rest for a week. I must confess to neither taking a proper history nor reading her past notes, and it was only after a further fortnight that it became clear that my present patient was having back trouble for the first time. She recovered her straight-leg raising fairly quickly—never having any motor loss and only slight sensory abnormality and reduction of ankle jerk—but two days ago after returning to her share of café duties (before she had my approval) she had a relapse and is now back to square one.

The patient has not asked for a specialist opinion yet, and I do not know whether to give nature another chance, to send her to outpatients for an x-ray examination to keep everyone happy, or to arrange for a domiciliary orthopaedic opinion.

General practitioner's comments

The way this problem is presented indicates that the doctor's problems have been compounded by his acknowledged guilt in not appreciating the relevant background to the initial consultation. This is not surprising when considering the present state of most general-practice record-keeping. A doctor who is new to general practice may not find it easy to obtain the past history of patients. This indicates how important it is to maintain a summary of diagnoses and treatment within the notes and to continue pressing for a more suitable record system for general practice.

What is surprising, however, is that a young doctor has started treatment without inquiring into past history and without examining the patient's back. One appreciates the difficulties this may entail, particularly when dealing with patients of a different cultural background to one's own, but basic mistakes of this kind indicate either being very rushed (which as a trainee he should not be) or not appreciating the necessity to examine properly (which signifies poor training). The guilt engendered by these mistakes should initiate a review of his consultation techniques together with that of the record system and the speed of consultation. Too often the guilt one feels after clinical mistakes is not used to improve constructively the doctor's method of working but is dissipated in self-justification.

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Back pain is a common complaint in general practice, and its management is certainly poorly defined. In this particular example the fact that the patient's sister has recently had an intervertebral disc removed complicates the picture considerably, as does the fact that the original pain has recurred. Both these facts are likely to influence considerably the future management of this patient. Questions such as "How long was the sister troubled with back pain before operation?" and "Has the operation improved the sister's back pain?" will have to be faced. The pressures on the patient to return to work were obviously great; it is important to find out what these pressures were. The answers to these questions will be needed to decide on future policy, as will a further examination to determine whether motor or sensory loss has recurred.

If the sister had had recurrent back trouble over many months culminating in an operation the doctor would probably be wise to arrange a domiciliary consultation, preferably with the consultant who dealt with the sister. Domiciliary consultations are valuable and hence expensive parts of the National Health Service and should be used judiciously. In certain cases, such as when there is uncertainty as to the best form of management or when criticism of the general practitioner's management has been made by patients or their relatives, they are of immense value, particularly when it may be difficult or impracticable to arrange an outpatient consultation. The opportunity for general practitioner and consultant to discuss together the ideal form of management with the patient can be of great benefit to all concerned.

Notwithstanding what had happened to the sister it is necessary to perform a full examination of the back, including the range of movements possible, together with an examination of the nervous system in the lower part of the body. It is wise to arrange a blood test for plasma viscosity (or erythrocyte sedimentation rate) and then to give a full explanation of the most likely reason for the recurrence and to arrange for bed rest on a firm mattress. A home visit is often essential in judging the adequacy of measures taken, for so often the patient will lie on a sagging mattress with pillows beneath the small of the back and under the neck, and advice to move to a firmer mattress or to the floor will result in considerable improvement.

If, with simple analgesics and bed rest together with a full explanation of the condition, the pain does not settle within a week or two an x-ray examination of the lumbar spine to help exclude serious disease would be sensible.

Fortunately, most back pain will settle quickly, and if advice "to keep the back straight" and "to avoid sitting in easy chairs or sofas" is followed there should be no recurrence. Telling the patient that all lifting should be performed with a straight back and bent knees rather than bending forward from the waist also helps to prevent a relapse. My own trainer used to recommend patients to think of themselves as fork-lift trucks rather than cranes, and this can be a useful analogy to use with some patients.

In the absence of serious neurological problems consultant help is rarely needed in the early stages of most low-back pain, and I usually only consult orthopaedic colleagues when the pain is not responding after two or three weeks to the simple measures outlined above. Patients sometimes ask about the advisability of osteopathic manipulation, and my advice is usually to wait to see whether simple bed rest will settle the discomfort first and then, if this fails to improve matters within a week, to suggest a doctor trained in osteopathic techniques.

Consultant's comments

There is nothing like an acute backache, particularly with associated sciatica, to produce a crisis in the home. The patient is not used to being ill and resents the pain and enforced immobility. "Just rest," even complete bed rest, is not usually accepted as "treatment" by the patient or relatives. Something more dramatic is needed to make the family and the patient feel that a positive therapeutic programme is being followed that is

likely to produce results. In a domestic scene as in this case, personal, familial, and business reasons all combine to produce pressure on the general practitioner to produce a magical and swift cure to get the patient back into her place in the family and the family business.

A domiciliary visit by a consultant, preferably one with an impressive personality and a warm heart, may have a greater effect in restoring calm and sanity than anything else. If a second and somewhat longer period of bed rest at home does not produce adequate relief of symptoms as the patient begins to mobilise, or if there is opposition to further rest or poor co-operation or civil war in home and restaurant then a domiciliary visit by a consultant with a personality able to cope with the conditions would probably help the patient, her family, and, not least, her general practitioner. To impress on a healthy, active woman that strict rest is a good idea and that it is treatment, and often very successful, needs a positive approach and indoctrination of not only the patient but the surrounding family. If other measures are later indicated, such as admission to hospital or outpatient treatment, the consultant can once again, having seen the patient in her own surroundings, help.

The consultant sees the patient in her natural setting, and backaches of all kinds are particularly affected by home and work environment. The treatment of such a lesion may later need considerable team work if the condition does not settle, and the consultant and practitioner are, after such a consultation, in a better position to organise any further treatment. Such an episode may resolve satisfactorily and symptoms subside on rest, but all too often, particularly if the therapeutic programme is rushed or abbreviated, this may be the beginning of a long and distressing illness, the distress affecting not only the patient but her community also. The fact that this particular patient's disorder is the second of its kind in this close-knit community complicates and intensifies the emotional overtones of the family and has a great effect on the patient herself. This patient probably felt that as her sister needed surgery to cure her prolapsed intervertebral disc lesion the same might well apply to her.

The value of a domiciliary consultation depends very much on the nature of the case (as well as the nature of the participants). (1) It may help in that a diagnosis may be made at the bedside that was previously missed, such as a pericarditis, a perinephric abscess, a rectal carcinoma, etc. (2) Steps may then be taken to admit the patient to hospital for further investigation, treatment, or home treatment may be planned. (3) The patient may be too crippled, or may be unable or unwilling or too ill to leave home and attend hospital as an outpatient; certain investigations can probably be organised in the home. (4) The home conditions may throw much light on the case. I remember one instance when a peculiar coma was explained by a strong aroma of alcohol detected in the patient's breath during inspection of the optic fundi, both wife and general practitioner being unaware that the patient was a secret drinker. The diagnosis was confirmed by finding the empty bottle of brandy, corkless, under the bed. The home consultation may also throw much light on interfamilial factors and relationships, loves, and hatreds, which sometimes explain many odd facets of the case. As has been said, take the roof off many a suburban, apparently quiet, sedate little homestead and you find a jungle beneath. (5) Patient and relatives may accept a diagnosis and line of management or treatment that previously they rejected, and in the case of a very ill patient the consultation may resign them to the fact that all has been done that can be done and that the patient should be allowed to die in as much peace and comfort as possible, and not, in the words of a cynic "investigated to death."

Reverting to the particular case of these two sisters, there seem to have been several sins of omission on the practitioner's part. A glance at the notes, or even at the patient, might have saved much trouble. Identical twins with almost identical names have baffled me in the past, but there is no such excuse in this case. Inspection of the records and taking all relevant

documents to the home, together with x-ray films, if available, is essential in domiciliary visiting.

Finally, what is the specialist's role in the management of routine backache? It is first to try and make a definite diagnosis or check on the diagnosis already made. In most cases the diagnosis is highly provisional, and further investigations are often necessary, for the backache may be a manifestation of a whole host of disorders ranging from an anxiety state with mild degenerative spinal changes to multiple myelomatosis. Admission to hospital or outpatient visits will be arranged and the future therapeutic programme organised in the light of the findings and clinical progress. In this case, if the condition settled down entirely satisfactorily no more would be needed; if mild or moderate symptoms persisted an outpatient consultation and appropriate investigation would seem to be indicated; but if the condition of the patient and the familial tension persisted unabated then a domiciliary consultation would seem the correct procedure but, speaking as a physician, with a

physician initially rather than an orthopaedic surgeon, though his services and opinion might well be required later.

Postscript to the problem

A domiciliary consultation was arranged with an orthopaedic surgeon. He wondered if tuberculosis of the spine might be present and arranged an x-ray examination at his outpatient clinic. This provided a nasty shock; metastatic tumour was seen, the source being an ulcerated tumour of breast, not mentioned by the patient and not diagnosed clinically by either general practitioner or specialist. The patient died two months later with brain and lung metastases. Fortunately, the profession redeemed itself in providing sympathetic and relevant care during the terminal period, and, as so often happens, the family were profuse in their thanks for the attention we had provided.

Medicine in the 'Seventies

Medical contrasts: Britain and the USA

An interview with Dr J M Forsythe

[FROM A SPECIAL CORRESPONDENT]

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When we think of differences between British and North American medicine, one aspect which may not be immediately obvious is the greater flexibility of the American system. Dr J M Forsythe, an NHS community physician recently returned from three months in the USA and this was, he thought, the most striking contrast. "What really hit me" said Dr Forsythe "was

Dr Malcolm Forsythe, MSc, FFCM, area medical officer, Kent Area Health Authority. Dr Forsythe served on the RAWP working party and has recently visited the USA as a result of the award of a Jack Masur Fellowship by the American Hospitals Association (as the nomination of the Nuffield Provincial Hospitals Trust).

that we have now moved to a state where the NHS is financed almost 100% by central government funds. When the reorganisation took place in 1974 we lost an important source of finance from local government. In the past, progressive authorities could innovate, if necessary, entirely with their own funds through the rates. We now have to rely on central finance—and work within a document on priorities which lists specific yardsticks for most of the services. Health authorities are going to be pressed to try and conform with these yardsticks. The room for innovation and flexibility in the service has diminished quite dramatically." He would like to see some development of

outside monitoring of the way the service was being delivered, and perhaps outside financing of innovations. Central government would always have difficulty in innovating because of its

need to consult with the professions and the unions. Something like 35 times more money was being put into health care by charitable funds in the United States than in Britain. In terms of individual giving the British contributed roughly £2 per caput to health and welfare from charitable organisations and in the United States it was about £20 per caput.

Approach to audit

Another contrast between the USA and Britain was to be seen in their approach to the concept of audit of process and of outcome. Dr Forsythe had no doubt that it had been developing in this country in a much healthier way than in the United States, where audit was being imposed. There the real motives were not quality of care: the Americans, and Congress in particular, were seeking to contain costs; and in their audit system imposed by legislation they were concentrating on length of stay and whether or not procedures were necessary. "To my mind that is totally missing the real issues, and in fact they are collecting the wrong sort of data for the measurement of *quality* of care." In part the difference of approach reflected the different problems: for example, they had an appalling problem of physicians "ripping off" the Medicare and Medicaid systems. But, Dr Forsythe continued, "that's the way their health service is run. It's not an organised health service, it's pluralistic. The government's role has been to create a whole series of programmes for specific purposes for which they have then developed a whole lot of regulations, which they have then had to monitor to see if they are being abused." He saw audit of quality of care as really being concerned with outcome. "In Britain at the moment we have no good measures of outcome. We can get case fatality rates of people treated in hospital; but the follow up of conditions other than cancer is very difficult. More important, we have no data on the satisfaction of people with the medical care they've been given; no data on iatrogenic