PRACTICE OBSERVED

Trainees' Corner: Managing Chronic Disease

Diagnosing arthritis

RAY MILLION, TERRENCE REILLY

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation. Further information about the video-cassette programme on which this series is based is available from the MSD Foundation, Turret House, Turret Square, London WC1.

Although this article deals with specific arthritides, we want to make some remarks about rheumatic disorders in general. When presenting evidence to the Royal Commission on the National Health Service the British League Against Rheumatism wrote:

"Rheumatic disorders are responsible for a large part of the general practitioner's work load, but all too often the quality of primary care for patients with these conditions leaves much to be desired. Doctors with special expertise, including some engaged in primary care, appear to be able to respond effectively to greater demands without distortion of their work burden. There is an urgent need for more relevant education for those intending a career in general practice as well as for provision of appropriate supporting facilities. A great deal of improvement could be accomplished without the need for additional resources."

During a year something like 150 patients for every 1000 on his list will consult a general practitioner with a rheumatic problem, and over the age of 65 this proportion may be doubled.

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Objectives

This article aims at stimulating trainees to consider the objectives of managing the patient with arthritis in general practice and in particular:

- to consider the methods available for diagnosis;
- to emphasize the need to detect early signs of the disease which might be aborted or have its subsequent course modified;
- to recognise and manage wide ranges of common conditions which need not require the more costly interventions of the hospital services;
- to gain insight into the factors requiring continuing care in chronic conditions.

In Britain more than 8m people consult their general practitioner each year with a rheumatic problem, and such problems account for the loss of some 40m working days each year. What impact can general practice make on this problem? The authors of the Brindle Lodge report wrote in 1974:

"Primary care in the community is the first line of contact for those with locomotor diseases. It was felt that with appropriate support and education and ready access to expert advice when difficult problems are encountered, general practitioners could deal with a large proportion of the management of these problems without the need for referral to hospital. Difficulties in diagnosis would, of course, still be likely to call for a specialist opinion in a number of instances."

Arthritis in its many forms is thus one of the commonest problems in general practice. Surveys have shown that musculoskeletal disorders account for between 20 and 25% of general practice consultations. They pose problems of diagnosis, investigation, and management. This article is in two parts: in

sanitation. He was a good parent and a concerned family man with regular but poorly paid employment. He was not a frequent attender at the surgery, but he had come because he was becoming increasingly worried about his painful knee. The doctor discovered that he had first noticed the pain when playing with his children. There were no medical records available, and he did not give a history of related or associated disorders. During the consultation the doctor elicited that there was no family history of hereditary disease and that his children, aged 5 to 14, were all at school and were well.

On examination the right knee was warmer than the left, and it had lost its normal flexion, suggesting an effusion. On moving the knee there was crepitus in mid-flexion and pain at full flexion but not at full extension. The patellar tap was positive on the right but not on the left. The right quadriceps measured 38 cm round 12 cm above the top of the patella as opposed to 40 cm on the left; this difference was probably important as Mahmet was right-handed. Further examination showed that there was no finger clubbing, no cervical lymphadenopathy, the trachea was central, and the apex beat not displaced.

So what was the diagnosis? This was a big problem and difficult to manage in general practice. From the history we had a man, a first generation immigrant, who had gone back to Bangladesh a year ago for a visit, who was now in Britain working, and who had a minor injury to one joint. The trauma might be dismissed by the doctor as a trivial event and the patient might be advised to go away, do something simple, take some rest and analgesic, and come back next week if it was still bothersome. And this could be a disaster.

He may have had the first evidence of an atypical form of an inflammatory polyarthritis, and one might be tempted to sit back and wait and see what happened. Conversely, you might think that he had got into an acute form, but the joint had been uncomfortable for a few weeks, which is not typical of gout. A septic arthritis was a possibility, and one might think it would cost him his leg or his life—a dramatic statement but quite true, and this was one of the most important points. Because of the findings elicited in the history, tuberculosis also had to be considered.

With this differential diagnostic dilemma this was the point at which the general practitioner should cease to work alone in the case. He should telephone a rheumatologist or, if not available, a consultant physician, and possibly ask him to come out and discuss the case. Specialised investigation was of paramount importance, and before the day ended that man should have been in hospital.

Mary Evans

The last patient was Mary Evans. She was also complaining of knee trouble but in both of her knees. She was 56 years old, overweight, and had had the pain in her knees for several weeks. The pain was bad enough to make her limp but was relieved slightly when she took the weight off her feet and rested. She also had pain in all of her right leg, down the side of the ankle, up to the hip, and into the groin. She had no other complaints and her previous medical history was unremarkable. To her doctor's frustration she had recently gained a little weight.

On examination her hands were normal and she had full painless extension and flexion in both of her knees, although there was some crepitus in the right knee. There was a fixed flexion deformity in the right hip and some loss of flexion in the left hip. How can you distinguish hip from knee involvement, and what is the cause of these symptoms?

This was a woman in late middle age whose sole problem was pain of fairly recent origin in the knees. The doctor found normal peripheral joints and elicited a positive Thomas test—the fixed flexion deformity in the right hip. She also showed that the knee, which the patient had said was being painful, were in fact mobile, stable, and had a little crepitus. An alternative technique for differentiating the source of pain between hip and

knee is to sit a patient on the side of a couch with the legs dangling free and the popliteal fossa cushioned by the side of the couch and then ask her to extend the knee fully, and if this is painful it is a good sign that the source of pain is the hip and not the knee. It was important to bear in mind that she had a limp and that the examiner had elicited some short shortening in the right leg. Such patients walk in a dot-and-carry-one fashion and often therefore complain of low backache, which may be a misleading symptom if leg measurement is not precisely assessed.

This particular woman had normal hands, but commonly an examination of the peripheral joints in the upper limbs is valuable because middle-aged and elderly patients have signs of generalised osteoarthritis in the form of Bouchard's nodes in the proximal interphalangeal joints or Heberden's nodes in the distal interphalangeal joints. In this instance there was no morning stiffness, and no synovial thickening, swelling, or tenderness was elicited anywhere. It was fairly clear that the diagnosis was osteoarthritis in the right hip. Steps would have to be taken to show that this was the case and that there was no other overriding cause for her symptoms, but that would be straightforward.

Diagnoses confirmed

We have now considered four patients with joint disorders: Brian; Doris; Mahmet; and Mary. We have studied their case histories, and we have made presumptive diagnoses of ankylosing spondylitis, rheumatoid arthritis, tuberculous arthritis, and osteoarthritis. What tests were necessary to confirm or reject each of these diagnoses? And which of these should be handled in general practice?

Brian Hall's presumptive diagnosis was ankylosing spondylitis. All test results were within normal limits, though the erythrocyte sedimentation rate (ESR) was at the highest limit of normal at 20 mm in the first hour. Urine analysis showed normal glucose and protein. X-ray examination of the dorsolumbar spine and sacroiliac joints were requested, and the first showed the changes typical of early ankylosing spondylitis. Some patients may show the later stages characterised by ossification of the spinal ligaments plus erosion and fusion of the apophyseal joints, the so called bamboo spine. In Brian's case the sacroiliac joint surfaces were eroded with sclerosis in subchondral bone. Brian had ankylosing spondylitis.

Doris Taylor was found to have a haemoglobin of 9.8 g/dl and an ESR of 75 mm in the first hour. Sheep cell agglutination and latex fixation tests were positive. Urine analysis showed neither protein nor red cells, and the throat swabs were sterile. The diagnosis of rheumatoid arthritis was probable. Mahmet Kashmi was admitted to hospital for investigation and treatment. His haemoglobin at 14 g/dl was normal, but he had an ESR of 66 mm in the first hour and a leucocytosis of $15 \times 10^9/l$. Aspiration of the joint and synovial biopsy specimen confirmed the diagnosis. He had a tuberculous knee joint. Mary Evans had a normal ESR as expected. The diagnosis was made on the x-ray examination of the pelvis. She had severe osteoarthritis of both hips.

So our four diagnoses are confirmed. Now come the problems of management, which will be discussed in the next article.

We are grateful to Dr Tom Smith and Dr Sally Hull, who helped with the preparation of this programme.

References

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the first we consider four typical patients, all with joint disease, who might present themselves at any surgery. You are asked to put yourselves in the position of their general practitioner. By the end of the first article their diagnosis should be clear. The second article deals with management, which of course encompasses much more than prescription writing.

The four pseudonymous patients who might present themselves in your surgery are: Brian Hall, a 30-year-old man with backache; Doris Taylor, a woman nearing 50 with pains in her joints; Mahmet Kashmi, a 40-year-old immigrant from Bangladesh with a painful knee; and Mary Evans, a woman in her late 50s whose knees are bothering her. At first sight they have little in common, yet they all have disorders of their joints, and a systematic approach to their problems will help to ensure speedy and accurate diagnosis and the selection of the most appropriate management.

Brian Hall

Brian had already labelled his own illness as sciatica, as his uncle had had a similar complaint some years ago. He came saying that the pain in his back had become bad again. His medical records showed that he rarely attended the doctor, and his only consultations had been for well-defined incidents. He dated his present symptoms from a fall two years previously. He was stiff in the morning, but felt better in the evenings. Exercise hurt, but later it relieved the stiffness.

Examination showed no scoliosis but some lumbar lordosis, and Brian indicated that he felt pain in his buttocks and between the shoulders. When he touched his toes the doctor's fingers, placed on his spinous processes, did not separate at all, indicating that he had a very stiff spine. When asked to slide his hand down his right leg and then his left leg, he could manage only about 10 cm movement on each side, showing that the limitation of movement was considerable but equal. When asked to lean back as far as possible Brian could not move his back but did all his leaning from his hips. Testing neck movements showed loss of lateral mobility. Pressure on the sacroiliac joints gave Brian pain, particularly on the left side. Finally, measuring Brian's chest in inspiration and expiration at the nipple line showed that there was only 2 cm of expansion.

So what was the next step and what were the possible diagnoses? Several features in the history were very important: one was that he thought he had sciatica; another was that he had morning stiffness; and a third was that he had pain both between the shoulder blades and in his buttocks. Fourthly, his stiffness was relieved by exercise. The examination brought out evidence of limitation of movement in the cervical spine, evidence of normal hips (the pain in the buttocks was a confusing sign because it could arise in the back and it could arise in the hip joints), the straight-leg raising test indicated that probably there was no most compression in the lumbar spine. This was important because he gave a history of having had a fall and he may have had a mechanical disorder of the back. The history suggested that this was not because of the morning stiffness and because of the vague distribution of pain—where it mechanical it would probably have been more localised. This man showed all the signs of an inflammatory disorder of the spine of some severity.

It is very important to understand that not every patient who has a disorder like this will show such obvious signs. In particular, the lateral flexion of the spine where the fingertips failed to reach the popliteal crease by several centimetres will not always be present. In an early case it may be possible to show that the symptoms are all the same, but the man may reach his popliteal crease and touch his toes with little difficulty. But the fact that he had difficulty with the pelvis fixed in rotating his dorsal and lumbar spine was a pointer to an inflammatory disorder in the spine.

So we have built up a picture of a man quite severely affected by a disorder that looked inflammatory in its history and in its clinical presentation; a mechanical disorder of the lumbar spine

was very unlikely to show limitation of rotation and limitation of lateral flexion but only of forward flexion and extension. This was a man with a spondyloarthropathy of the ankylosing spondylitis type, and we would want to do further investigations to make a more accurate diagnosis.

Doris Taylor

Doris was 48, and her record folder was remarkably thin. She had had few clinical problems, but she was very upset: in recent months she had developed pain and swelling of small joints all over her body. She had morning stiffness for two hours and felt feverish and vaguely unwell. Obviously, the first diagnosis that came to mind was rheumatoid arthritis—but how to confirm it?

Examining Doris's hands showed typical spindling and some palmar erythema but no vasculitis of the fingertips. There were no subcutaneous nodules to be felt. Squeezing the proximal interphalangeal joints was painful, but extending the fingers Doris described as uncomfortable rather than painful. The distal interphalangeal joints were normal. Extension of the wrist joint was painful on both sides. The doctor felt for nodules or trigger fingers by placing her hand on the flexor tendons and then flexing and extending the fingers—she could not feel anything. Doris had difficulty putting her hands behind her neck and her back. Trying to abduct Doris's right arm with her scapula fixed, the doctor showed a considerable restriction of glenohumeral movement, but when she took her hand off the scapula further elevation of the arm was possible. There was no limitation of movement in the neck, and Doris reported that movement was not painful but was noisy. She had no pain on opening her mouth wide. Further examination showed tenderness in the joints of the forefeet.

Doris again

With Doris we can piece together a picture that is fairly conclusive. In the last few months she has had some pain with a lot of stiffness in the morning, and this had affected her mainly in the joints of the limbs. She had felt ill; she had not been able to get about and fulfil all her responsibilities; and she had been disturbed for all those reasons. The examination showed that she had pain, tenderness, and limitation of motion in a lot of joints: in the small joints of the hands—the distal interphalangeal joints—and the wrists, the shoulders, and the forefeet. The conclusion we reach is that the inflammation is in soft tissue, in synovial tissue. The examiner has tried to elicit tenderness in the temporomandibular joints; people sometimes spontaneously complain of difficulty in chewing their food, and, of course, that is a synovial joint like the others. So we have a picture again of an inflammatory arthritis, but this time affecting the peripheral joints. It affects them symmetrically, is of recent onset, and omits the distal interphalangeal joints—this is a diagnostic pointer. We can conclude that she has an inflammatory polyarthritis of the rheumatoid type.

The general practitioner must decide whether this is rheumatoid arthritis or whether it is one of a variety of disorders that mimic it: psoriatic arthropathy; sarcoidosis; systemic lupus erythematosus; or polyarteritis nodosa—rarer syndromes. A general practitioner would not be expected to deal with. Now complex investigations are needed, but the general practitioner will be able to organise these.

Mahmet Kashmi

The next patient was 40-year-old Mahmet Kashmi. Mahmet had come to Britain several years previously from Bangladesh and had returned only once, last year. He now lived with his wife and children in an overcrowded terraced house with poor

Organising a Practice

A general practice expands

P G KAY

There has been a tendency for group practices to get larger in recent years. This paper describes how one large practice is coping with further expansion. Large practices have their own administrative problems, and perhaps it is time that we took stock to identify these problems and discuss solutions.

Setting

The practice is based in Witney, an old market town 12 miles west of Oxford. Two-thirds of the patients live in the town, and the remaining third in villages, mainly within five miles of the town centre but up to eight miles in one direction. The main employers in the town are a car components factory, the ancient blanket-making industry, and a food processing factory. Many small industries have grown up recently, and the area acts as a dormitory for Oxford. There is a full spread of patients throughout the social classes, with classes 3 and 4 predominating.

Since 1948 the family practitioner services in the town have been provided by one practice, which had grown to six partners by the late 1950s. On the periphery of the practice there is territorial overlap with neighbouring practices. A branch surgery, owned by the practice, is in a village six miles from the town centre. There has been no cottage hospital in the area, so we looked to Oxford for all hospital services, except that orthopaedic and ophthalmology clinics were held on a regular basis in a church hall.

The 1960s

By the late 1950s the rented practice premises had become too small. After extensive negotiations the Nuffield Provincial Hospitals Trust agreed to finance a health centre to bring together the three strands of the health service—hospital, local authority, and general practice—under one roof. At the end of 1965 the partners moved into the Nuffield Health Centre, which provided them with a suite of six consulting rooms, an examination room, a treatment room, reception area, and secretary's office. There were rooms for health visitors and district nurses, who had previously worked from their homes. There was a physiotherapy department under a physiotherapist, a small x-ray department, a small x-ray department, capable of taking chest and "cold" orthopaedic x-rays, and a suite of consulting rooms for visiting specialists from Oxford who held outpatient clinics between the doctors, the district nurses, and health visitors increased rapidly and an effective primary care team was built up, while the links between the team and the hospital services steadily improved.

Witney Health Centre, Witney, Oxon
P G KAY, MR, MRCP, general practitioner

At this time the population was expanding fast—about 500 extra patients a year were being added to the practice list—so that by 1968 there were an average of 3000 patients per partner. We felt we were a large enough group, but we also realised that this number of patients was too large for good practice so we decided to take on two new partners in the next three years. We were able to take over some rooms in the Nuffield Health Centre as consulting rooms.

The early 1970s

We became a training practice, which added another "pair of hands," but we soon realised that the advantages were balanced by the time taken up in teaching.

At the beginning of the decade the local planners predicted that there would be 31 000 people in our practice area by 1981—a further 10 000—and we knew that there was no room for further expansion in the health centre. In the early 1970s the Oxford Regional Hospital Board planned to develop its community hospital programme and wanted to site a new community hospital in Witney. In 1972 it decided to do this and include a new health centre as part of the building. It was agreed in principle that half of our practice would move into the new centre. A planning team included two of the partners.

In the Nuffield Health Centre there is only one examination room, the treatment room is some distance from the consulting rooms, and the reception area is too small. We used our influence to ensure that the reception area was much larger and that the treatment room was close to the consulting rooms. The health centre design guide at the time insisted on one examination room for each consulting room and, though we thought that these would be too many, they were provided. The project was ready to go to tender by the end of 1973, when, because of the sudden cut-backs in public expenditure, the project was shelved.

The mid-1970s

The Oxford Regional Hospital Board was replaced by the Oxford Regional Health Authority, and the Oxfordshire Area Health Authority (Teaching) (OAHAT) came into being. Of the original planning team only the two GPs and one nursing officer remained in the area. When limited funds became available it was decided to build the health centre as a separate block. Work started in 1976 and was completed by the end of 1977. It provided eight consulting rooms and examination rooms, a treatment room, a large reception area, a health education room, and offices for the district nurses and health visitors, with a medical loan store and chiropody room.

At completion, the OAHAT had no money to allocate for the costs, and the predicted population expansion had not occurred. So the practice was several thousand patients smaller

than expected and could not bear the extra costs of working from two centres. Reluctantly it was decided to have the health centre "mothballed."

The late 1970s

By the end of the winter of 1978-9 the population had increased to about 22 000, and we were beginning to feel stressed. A revised and tentative prediction from the local planning department was that we could expect 26 000 people in our area by 1986. The records shelves were already full, the telephone switchboard was overloaded, and all the rooms were being used full-time.

In June 1979 the practice wrote to the OAH(A/T), saying that it needed to take on a ninth partner in the near future but could only do so if the new health centre were opened. After negotiations in mid-December, it was decided to open the health centre by the end of March 1980. This was conditional on (a) locating the Mid-Oxon nursing officer and his secretary in two of the consulting rooms (only six would be needed by the practice in the immediate future, but it was agreed that the others could be "reclaimed" when needed); (b) locating the nursing officers for health visitors and district nurses in vacant rooms in the Nuffield Health Centre; and (c) locating a newly formed community team for the mentally handicapped in rooms in the new health centre, which would be called the Windrush Health Centre.

The practice splits

It was decided about three years before the Windrush Health Centre opened which four of the partners would move, and it was also decided that we should remain one partnership. Once we had a date for opening we had to make detailed arrangements.

ADDITIONAL PARTNER

An extra partner was appointed in September 1979 to start practising on 1 April 1980 in the Windrush Health Centre. This left four partners, the permanent part-time assistant, and the trainee in the Nuffield Health Centre.

SECTARIANS

For 15 years our secretary had acted as supervisor of the Nuffield Health Centre on behalf of the Oxfordshire County Council and subsequently for the OAH(A/T), who are agents for the Nuffield Foundation Hospitals Trust. It was decided that she would stop this dual function and work entirely for the practice on a part-time basis. She had been assisted by a part-time secretary, who would move into the Windrush Health Centre.

RECEPTIONISTS

The practice employed seven full-time receptionists. We estimated that to staff a reception office from 8.30 am to 7 pm would require four full-time and one part-time receptionists. We decided to employ as senior receptionist in the Windrush Health Centre a woman who had worked for the practice before and wished to return to full-time work. The others were asked to decide which of them should move and which should stay. Within a week they had worked it out to everyone's satisfaction—which saved the partners from having to impose a decision.

TREATMENT ROOM NURSES

We had employed one nurse full-time and one in the mornings only. We decided that we should have the equivalent of one full-time nurse (9 am to 5 pm) in each treatment room, giving cover during lunchtime. We also decided that we should have one nurse in each centre from 5 pm to 7 pm, who would also work in the reception office. Four nurses working different lengths of time staffed the treatment rooms and had additional responsibilities for writing repeat prescriptions and assisting the receptionists.

Our total employed staff would be about 12 full-time equivalents—well below the two per principal allowed for in the Statement of Fees and Allowances.

ATTACHED OAH(A/T)-EMPLOYED STAFF

It was decided that the district nurses and health visitors should split into two groups and half move into the Windrush Health Centre. For years our arrangements had been for health visitors and district nurses to be attached to just one or two doctors and be primarily responsible for their patients. But the nursing administration had wished to change this method of working so that each health visitor and district nurse had a geographical area within the practice. It was decided to impose this, against the wishes of the doctors and the health visitors, at the time of the split. There would be three district nurses and three health visitors working half the hours of the practice, but each had a third of the practice area to cover.

The move

The patients' record envelopes are filed alphabetically, males and females separately. About two months before the move, the records of the patients registered with the doctors who were moving were identified, marked with a red sticker, and filed separately from the rest. Supplies of all the various forms were collected and moved into the Windrush Health Centre during the last week in March. Treatment room supplies and equipment were divided into two, shortages identified, and new equipment purchased when necessary to ensure that both treatment rooms were fully equipped.

A new practice information card was printed and distributed to all patients who had been seen from about six weeks before the move. Notices informing patients of what was happening were displayed in the waiting room. It was decided that, as the new building was so close to the old one, there would be little inconvenience for patients who turned up in the wrong place, so there was no need to go to the expense (about £1200) of circulating all patients through the family practitioner committee. Instead, many patients attended or phoned the wrong health centre during the first few weeks, but the numbers doing so rapidly diminished.

As soon as the Nuffield Health Centre closed after morning surgery on Saturday, 29 March, we started moving the record envelopes (about 11 000) and other equipment. All partners and reception staff worked hard and cheerfully, so that by early evening both centres were organised and ready for Monday morning.

Progress

The partnership has remained intact. For many years the doctors have met over lunch every Friday and continue to do so. Inevitably, the main contact each doctor has is with those who work in the same centre, and it may be that in time each group will have developed the differences between a formal split of two clerical and nursing staff and claim "two," reimbursement of their salaries. Our staff numbers are well inside our entitlement but are sufficient for our needs. Clearly we have a responsibility to help keep the Health Service costs down by not employing more staff than necessary, quite apart from watching our own expenses.

We are now responsible for our share of the running costs in two buildings, so there has been a big increase in our expenses. We take some comfort from the fact that our costs were relatively low before and that the initial increase was cushioned to some extent by occurring in a year when we received a large increase in remuneration as a result of the Review Body award in 1980.

Over the years we have tried to predict our future needs and cater for them. But predictions are not easy, especially on population changes. Our experience has been that room must be left for as much flexibility as possible in planning. Only time will tell what happens in the future. With more house building in the area the number of patients will increase. Will we get too big and decide to split into two practices? Will the complexity of our organisation become too much and encourage us to have a full-time business manager? Will we be able to avoid becoming bureaucratic and retain the humane element so essential to good general practice?

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became, so to speak, attached to her exoskeleton, and as her only travelling was between bedroom and kitchen it did not inconvenience her. Tentatively I packed at the mouldy stucco, but it was clearly going to take a long time to remove, and I was uncertain as to where the plane of cleavage lay. I referred her to the orthopaedic department of the neighbouring hospital.

The orthopaedic registrar was made of sterner stuff, and reported that the cast had come away quite easily, leaving an intact if rather feeble limb. I wish I could report a happy ending, a joyful return to the world. Alas, after her second attendance at the physiotherapy department she had a massive coronary thrombosis and died. Perhaps I should have left comparatively well alone. —SARAH SAVAGE, periparturient general practitioner.

We will be pleased to consider for publication other interesting clinical findings in general practice.—Ed., BMJ.

Interesting GPs of the Past

George Stebbing: 1749-1825

DAVID VAN ZWANENBERG

I should like to have known George Stebbing because he established a reputation as a kind, cheerful, and conscientious general practitioner in Ipswich at a time when there were very few effective treatments available, so that his success must have been largely due to his personality. He had started his medical career in Ipswich when he was first apprenticed to Mr Ashley in 1765 and practised in the town until a few months before his death in 1825.

He seems to have achieved his success as a practitioner by a genial and sympathetic outlook on life, and it was said that he always chatted agreeably with his patients. His geniality sometimes got the better of him and he acquired a reputation as a practical joker, but the exact nature of his pranks was not recorded. He was eccentric in other ways: he kept unusual animals such as a talking parrot, a snake, and some tortoises and always insisted that he would only pay his bills if they were presented to him at 8 am on his own doorstep.

In appearance he was a rather tall, thin man with a ruddy complexion who trotted round the town with a quick but slightly limping gait, which became more of a jog trot as he grew older, and he usually hummed or whistled to himself as he went on his way. He was always neatly dressed in black coat, waistcoat, knee breeches, silk stockings, and shoes with silver buckles. He wore his hair fairly short and was clean shaven, unless shaving twice a day.

After his marriage he lived in an unfashionable district in a large house surrounded by a sizeable garden with a high brick wall round it. George was an industrious gardener and was president of the flower show for many years until his final illness prevented him from attending in August 1824. His other great hobby was shooting—he was a notable shot and still successfully shooting snipe when he was over 70.

Mothers and prisoners

At that time each parish in Ipswich had its own arrangements for caring for its poor. George became surgeon and apothecary to the poor of St Margaret's parish in 1769 until his death. He celebrated 50 years of this work by giving the poor of the parish a Jubilee Dinner in 1819.

He married about 1770 and had a son and a daughter. Unfortunately his son died while still a young man in August 1791. George thereupon dispatched his daughter to London so that she could be trained as a midwife. He was very concerned about the lack of help available to poor women in labour, and his daughter's return he managed to persuade the ladies of Ipswich to establish a Lying-in-Charity. He became the first

Foxhall, Ipswich

DAVID VAN ZWANENBERG, DM, consultant physician

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DAVID VAN ZWANENBERG

surgeon and treasurer and his daughter the first governor of this charity. Any subscriber was entitled to give a card to a poor pregnant woman, which enabled her to call on the services of a midwife and a surgeon during her delivery and also allowed her the use of a set of baby linen. The charity flourished and for the next 100 years helped between 200 and 300 women each year. Stebbing worked for the charity until 1811, when he was over 60. His daughter ceased to be governor in 1801 but continued as a midwife for over 50 years, and her services were in great demand, especially for the wives of doctors. The Lying-in-Charity was replaced by other arrangements for midwives in the twentieth century, but it continued to loan out sets of baby clothes until 1940.

As a young man Stebbing was concerned in two cases that achieved some local notoriety. In 1778 he was called in the early hours of a December morning to attend the landlord of the Green Man, an alehouse down by the docks, who had been severely injured in a scuffle with a press gang. The landlord died a few hours later from a head injury, and the coroner ordered George Stebbing to perform the postmortem examination, which showed that death was due to a subdural haemorrhage. The local magistrates were so incensed by the actions of the press gang that they committed the whole gang to be kept in custody until tried for murder at the local assizes. Stebbing gave the medical evidence at the trial and his name was known throughout Suffolk thereafter. At the trial the judge discharged all the prisoners because there was no evidence to indicate who had actually dealt the fatal blow.

In the second case a small child had been left at St Margaret's Workhouse in a pitiable condition. It was Stebbing's evidence to the magistrates that this child's life was in danger owing to the cruel treatment that she had endured from her guardians that led the magistrates to issue warrants for the guardian's arrest. Possibly as a result of the controversy that he had had with the magistrates he was appointed in 1786 as surgeon to both gales in Ipswich, the one that belonged to the town as well as the county gale. He held both these appointments for 39 years until he was too old and too ill to carry on. On his resignation the county authorities gave him a vote of thanks and a double salary for his last year.

His work for the poor of the parish and for the prisoners in

the gales meant that most of his work was among those who

are now called the underprivileged. His services to the poor

were acknowledged after his death when the Parish Council of

St Margaret's presented his daughter with a purse of 20 guineas.

The greatest medical advance in his lifetime was Jenner's

discovery of vaccination, which was published in 1789.

For many years before that date the inoculation of smallpox

had been practised extensively in Ipswich, largely owing to the

Sutton family. There was considerable local controversy about

the inoculation technique since many doctors realised the

danger of spreading smallpox. Stebbing was one of the Ipswich

doctors who pledged themselves to inoculate only those brought

into the town not to inoculate any strangers from 1772 onwards.

business side of the practice is centralised. With consultant clinics, x-ray examinations, and physiotherapy still taking place in the Nuffield Health Centre, partners from the Windrush Health Centre are frequently "across the road." The community hospital has now been built, is next to the Windrush Health Centre, and opened in April 1981. Staff are encouraged to accept that they work for one organisation, the reception offices work closely together, with deliveries of mail, etc. three times a day and exchange of receptionists from time to time to help with holidays and sick leave. The treatment-room nurses cover for each other at lunch times and other times, if necessary. In both centres problems have arisen over employing nurses/receptionists in the later part of the day, so now part-time receptionists have taken their place, and we close at 6.30 pm.

The health visitors have become more used to their area but each health visitor now has to work with four or five doctors and each doctor with three health visitors, so that liaison is not as close as it was and is more time-consuming.

Our trainee has a room of his own in the Nuffield Health Centre for the first time and we have now taken on a second trainee based in the Windrush Health Centre and so expanded our teaching commitment.

Discussion

One problem of large partnerships is that too many doctors may see any one patient. We try to avoid this by each doctor having a list of patients who will only be seen by another partner if their own doctor is not available. The doctors work in pairs so that, for example, Dr A is not available Dr B will see Dr A's patients, and vice versa. This system works only during "office hours," and we employ a locum to cover holidays. But it does reduce the number of doctors any one patient is likely to see and gives the receptionists clear guidance about which doctor is responsible for each patient.

As practices get bigger the problem of organisation increases, and the need for consultation between all members of the practice—partners, employees, and attached staff—also increases. Although most of the routine work can be done by staff it is important that they have proper supervision. This practice is run by each partner having responsibility for one or more aspects of the working of the practice, and one is elected chairman. Formal meetings are held monthly. It would probably be more efficient if one or two partners were given responsibility for the whole of the everyday administration, with the group being responsible for policy. Many practices have a designated manager to see to all the details of management. Recently our secretary's role has increasingly edged in that direction, but handing over full responsibility is not acceptable to all the partners.

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