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.

SECRETARIES

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?

I think Mrs Freda Bird for typing this paper, and also my partners and all staff in both health centres for forming a friendly team which made possible the development described.

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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. —ANN SAVAGE, periparturic 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, usually 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

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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 governors 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 gaols 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 not to inoculate any stranger brought into the town nor 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.

Some have advocated greater use of attached staff to allow

Clinical Curio: plastered to last

It was over 20 years ago now that I was serving my apprenticeship in general practice, doing evening surgery so that I saw only the relatively mobile. I also did the occasional Saturday morning visit, however, and thus it was that I found myself at the bedside of an elderly lady with bronchitis. I examined her chest, prescribed, arranged a review, and was just about to leave when her equally elderly husband, who was a challenging eye and demanded, "What about her leg, doctor?" "Well, what about her leg?" I was late, the traffic terrible, and the family waiting, fidgeting like for their lunch. Silently she drew back the bedclothes, and I stared down at the green frable mouldering mass that replaced her right leg.

The story was a simple one. Some 15 years earlier, at the beginning of the war, she had been caught in the blitz and her leg fractured. The local hospital had applied a plaster cast, but somehow the follow-up appointment had never been made, so the never better cast. She

Jenner's system of vaccination was not accepted by all doctors initially, as many preferred to continue the earlier method of inoculation. Stebbing was one of the few doctors in Ipswich who decided in 1780 that they would form a Vaccine Pock Institution for the purpose of vaccinating the poor people of the town free, and he later declared in the local newspaper that in future he would only use cowpox. As a result, he was appointed an official inoculator and corresponding member of the London Vaccine Institute.

His surgical colleagues accepted him as a local leader in the profession as he served as president of both the Suffolk Society of Surgeons, which was purely a clinical society, and the Suffolk Benevolent Medical Society, which was a charity to assist the widows and orphans of medical men. His name is

ONE HUNDRED YEARS AGO Christina Marshall was born in the village of Chapeton, Lancashire, in the year 1867. While from her father she might have inherited a vigorous and robust constitution, by her mother she could fall heir at best to a system generally weakened, and probably specially tainted, from the fact that its development was coeval with that of pulmonary phthisis, which, six years later, deprived her of a maternal guardian. The family, of which she is the third youngest, consisted, when entire, of nine members. Their number has been reduced by three deaths: one from scarlet fever and two from consumption. The remaining six, although by no means the hardest, have not as yet shown any decided tendency to the development of the mother's fatal complaint; and, further, to those six patients it is decidedly the least serious. They have been provided for through the exertions of the father as a road surface; and the result of the upbringing has been comparatively favourable, albeit mentally and bodily, in the case of Christina. As to her personal history, I am told that, when three years old, she was the subject of a rather peculiar ailment, which was shown chiefly in the development of a strong craving for sugar, and an equally strong aversion to all that had previously been her staple diet. This state of matters extended over three months, and during this time, life was maintained by beef-tea. From the age of three onwards till last May, no incidents of her life are at present of much interest. She was often a little ill, seldom seriously; and her parents were never made cognisant of any distinct formation of tubercle in the lung or other organs. She had pleurisy, ophthalmia, which left much dimness of vision, and she was harassed with frequent and severe attacks of headache, probably gastric in their origin. Owing to these circumstances, her attendance at school was irregular; but the breaks were of short duration. She was an intelligent girl, was possessed of a disposition which was above the average in its liveliness, and was temperate with a quiet and becoming thoughtfulness, which at no time merited the term melancholy.

Exactly a year ago, she contracted a cold, and this not seeming to leave her, I was asked to see her on the middle of the last of July, when she was suffering from bronchitis of a moderate type, and was led by the general symptoms and the local chest-examination to negative any idea of a phthisical element in the case. From the fact that she was the course of a week or ten days, to be immediately tortured with a headache, which has continued more or less ever since. During the autumn, she was able to be out a good deal, and, towards the end of the great change came over her disposition and general condition. She now seldom spoke, almost never except when questioned; and she uniformly maintained a sullen and morose cast of countenance. She became very averse to taking food, extremely constipated, and sleepless, and all those symptoms have since gone on more and more firmly until, on the 18th last, she lay down on the bed, and, with her eyes shut, she went out for the last time, and then only for a few minutes; and, on January 8th last, she lay down on the bed, and she has not since wakened. Eighteen weeks ago, she took a small piece of fruit-cake, and

since then, her parents distinctly assert that no food of any kind has passed into her stomach, and that all their most earnest entreaties to get her to take food have resulted in failure. She takes water freely and occasionally sweets; but of these only a few, and not by any means frequently; and, lastly, she herself distinctly asserts, when pressed to take nourishment, that she cannot swallow, she begins to cry, and becomes very excited. When deluded into taking a mouthful of water with a little milk in it, she instantly rejects it. When reminded that she will die, she answers that she has the inward feeling of approaching death, but that no efforts of hers are powerful enough to avert the doom of swift approaching fate.

Though Christina's body is very emaciated, but free from borbories, the complexion is very sallow, the lips pale and dry, the tongue clean and dry. The throat is abnormally high in colour, dry, and the situation of a choking sensation. Pulse 82, regular, but very weak. On each corner, there is an abango. Headache is constant and severe. She has pain over the stomach and bowels, increased on pressure, and severe and continuous in character. The lungs are normal, if I except the slightest suspicion of dullness over the left apex. She has no cough, and the heart's sounds are normal, but the impulse very weak. She occasionally vomits a glairy mucus, and, while the effort entails leaves her much exhausted, it gives a transient relief to the gastric pain. The urine is scanty, pale, and deposits some urates, but is free from albumen. The bowels have not been moved for eleven weeks; and previously to that the intervals were five and six weeks. Then the motions were dark, scanty, and very hard. She is quite unable to leave her bed, which is in a small room, and so situated that it is impossible for her to reach any of the food-stuffs. Her parents have now ceased offering her anything beyond the water and sweets. The only persons who see her are the father and stepmother who alternate at overnight with her sister and brother, respectively eleven and eight years old, who reside in the house; and three older ones, who visit her at intervals. When I have named these, and added the clergyman and myself, I have given everyone who has any regular communication with the room.

I have now followed this case carefully from the earliest years of the girl's life up to the present time. I have put on paper the results of my inquiries amongst the attendants, and added thereto my own medical examination of the case. I can vouch for the truth of none of the statements made to me by others, but I may fairly close this rather mysterious record by saying that I have known the father and stepmother for six years, that they are in easy circumstances, that I believe the honesty and integrity of the father and mother to be above the faintest tint of suspicion, and that I have never, in all my connection with the district in which they reside, heard even the gentlest murmur of gossip pointing in the direction of latent channels of supply of food.

May 5th, p. 1. I have just had word from Scotland that the girl Marshall is gradually losing strength, but is quite conscious. There is no other important change. (*British Medical Journal*, 1881.)