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research appointment with the Medical Research Council and started a new professional life as a general practitioner, while keeping my tutorial commitments at St Peter's College, Oxford, where I was (and am) a fellow. I was at that time under powerful internal pressures to seek clarity in my own life and work, and the idea of dealing with the homeless was particularly appealing to me as I too had found it necessary to opt out of something. I had also a great deal of sympathy with the plight of those who could not quite adapt to the grinding disciplines of home and work. So when the post of physician-in-charge of the Centre was advertised in the second half of 1977 I applied and was chosen for it.

From its very start the job imposed certain guidelines: one had to be aware of the fragility of human contact, to be available, clear, natural, conscious of the manipulative possibilities of situations and aware that one's own inner need to feel effective might well blur the quality of one's judgment and actions. I was very lucky that the other members of the staff were like-minded and could also feel a kind of ease with the great variety of young human misery that we came across. We felt that trust could only be gained from this sort of natural availability that we attempted to put across and the pains we manifestly took to get the necessary information about our patient from the moment he arrived.

The receptionist's role has therefore had to become blurred—she is the first to see the patient, and her responsibilities were not dictated by bureaucratic guidelines but by her capacity to understand the patient's story, to evaluate its possible denotations, and to act according to pragmatic principles. Each encounter is thus felt to be a unique event, requiring a unique solution. This need not be a medical consultation, and a suitable referral to a voluntary or other agency might be the outcome—in which case the doctor is not concerned. Thus a referral might be made to one of our sister organisations in the WBCVS, such as the Soho Project (for help with housing and social problems), Centrepoint (who run an emergency night shelter at New Horizon (with a most useful and active day centre). If the problem appears to be a medical one then past medical histories are checked on the telephone there and then, and the information given to the doctor. The special nature of the centre has dictated rather firm prescribing policies—no sedatives, tranquilisers, hypnotics, or potentially addictive drugs (we are even wary of people who ask for cough mixtures) are prescribed. We have to be seen to be clear-headed, because this is the only basis of our reliability and authority. It has been our experience that this policy has ultimately been appreciated by our patients and has enabled us to establish relationships with them that are creative because the elements of mutual manipulation and collusion are absent. Trust after all can only develop when what is being offered is real; there is no room for the looseness of thought and the cosmetics that are generally associated with the desire to be sympathetic and helpful. A good example of this is a young girl who walked into my consulting room with a request for tranquilisers. On inquiring the reason for her request, it transpired that she had got married eight weeks before and had become increasingly alarmed at her husband's heavy drinking. I pointed out that any tablets taken by her were unlikely to cure him. I asked her permission to call him in, and as a result they both left the room greatly relieved that we had made arrangements to tackle his problem.

One may well ask what we have to show for our efforts. One answer can be given by the attendance figures. In under four years we have seen over 2000 patients and carried out over 7000 consultations. A full statistical study of the type of patient, of the presenting symptoms and diagnoses, of patterns of repeat attendance, prescribing, and referral will be published. This research has been carried out by an evaluation team comprising

the district community physician, a lecturer in sociology at Birkbeck College, London, and the administrator at Great Chapel Street Medical Centre. The figures, however, do not tell the whole story, and perhaps an anecdote might illustrate what the centre has come to mean to some of its patients.

Joe has been known to us since we started, drifting in and out with minor complaints and obviously grateful to have somewhere to consult. His inadequate personality and his congenial facial palsy compound the unfortunate face which he presents to the world. Recently he started to have seizures and was admitted to hospital as an emergency. A sick-sinus syndrome was diagnosed and a pacemaker was suggested. On hearing this, he promptly discharged himself. The hospital contacted us urgently, pointing out the hazards he could face. We managed to trace him, and I spoke to him on the phone. He came to see me that afternoon and I persuaded him to go back to hospital forthwith, which he did. He now has his pacemaker. I feel that this outcome would not have been possible without the trust that had developed between us over several years.

What I have learned

It may be relevant to summarise the lessons that I have learned from my association with the Great Chapel Street Medical Centre.

(1) The most important is that the personalities of the staff and their inner resources are what, in the end, count most. It is no coincidence that the members of my own surgery staff are both former patients of the centre.

(2) Given that this is so, the role of administrators, receptionists, students, nurses, and doctors need no longer be subject to the constraints of orthodoxy. Good eyes and ears can be put to good, and sometimes unexpected, use.

(3) This view of medical practice has had a profound impact on a number of preclinical medical students for whom I have had tutorial responsibilities. During the three years that they spent at Oxford (which have included vacations spent in part with us in London) they have displayed a keen interest in all aspects of the practice—administrative as well as social, pharmacological as well as medical. Some have indeed continued a close association with us during their clinical training.

(4) The welfare of the homeless who are ill has demonstrated the need for a sick bay for patients who require care but who are not ill enough to be admitted to hospital. Furthermore, some of my former (and present) students have expressed a preference for a way of living during their clinical training in London that is to them more appropriate and meaningful than staying in hostels or lodgings. As a result they and my surgery staff have planned a scheme for a sick bay manned by them under our supervision where their different needs will be met. We have every hope that this will become a reality in the very near future.

(5) The constraints of dealing with homeless people have prompted us to be intolerant of trendy jargon and of vague aspirations. Like W B Yeats I pray that

God guard me from those thoughts men think

In the mind alone

He that sings a lasting song

Thinks in a marrow bone.

"Audit" has been used in the last iffy. By that unfortunate term is meant an awareness and an acceptance of responsibility for one's choices, then that to us has become as natural as breathing and as vital—extending beyond the confines of professional life. But that's another story.

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meticulously. Important points cannot be trusted to memory but must be written down, and it is often helpful to jot down the next steps you thought of taking. For example, "See again in one week; if no better full blood count and chest x-ray" at least gives you other half an indication of the way you are thinking. It helps to agree on a practice policy about managing conditions. If we are all saying the same thing about length of time on treatment, use of drugs, the need to investigate, and so on, patients seem to get some confidence from this. Thirdly, it helps to introduce patients to your "doppelgänger." I explain to the patient that they need to be seen in two days and I bring my partner in and tell him or her the story in front of the patient. Lastly, I have enormously efficient (and tolerant) secretaries wherever I work, who form a communication link that usually plugs the gaps. Not always—I was chairing a conference at 9.30 am on a recent Saturday when I had a

message that the waiting room was full for my surgery 40 miles away. Not my fault this time, thank heavens.

If I somehow manage to deal with the organisational problems of having two jobs I find the second problem insoluble.

Conscience is not, for me, a hard task-master—it is an intolerable one. To a part-timer in two (or is it three?) jobs the full-time always seems better at any one. I suppose that each job contributes vicariously to the other and makes one better, but it is a message I cannot really absorb and it accounts for many a restless night. It is not helped by some of my peers who feel anxious to counter every proposal by saying, "That's all right for you, but a proper general practitioner..." And it is no use my pointing out that I probably see in my 20 hours of consulting as many patients as they do, that I don't have a half-day, and that I have been either on call or away working for the past 16 weekends. I still feel part-time!

Interesting GPs of the Past

William Price of Llantrisant—1800-1893

JOHN CULE

My father used to tell me that when he was a boy he had often seen Dr William Price, dressed in his red and green suit, dazzling brass buttons, and a foonk hat reminiscent of Davy Crockett, walking along the streets of the old market town of Pontypridd. This colourful general practitioner was outstandingly eccentric. The doctor informed one of the many judges before whom he appeared. "This is the military uniform, my lord, worn by Welshmen when they defeated you Englishmen at the Battle of Bosworth Field nearly 500 years ago." At least he got the colours right. For his headgear he claimed even greater antiquity. "The fox is represented as one of the first beings in the hieroglyphics of Egypt. The primitive bard and the druids always wore foxskins as headcoverings." In my father's generation he was used as a threat to naughty children. By the time of my own boyhood he had already become a fable.

Dr William Price was among the first to emerge after the Apothecaries Act of 1815 with the double accolade that was to distinguish the new breed of general practitioners. After apprenticeship to Evan Edwards of Caerphilly, Price attended at both the London Hospital and Bart's, where he was instructed by the great John Abernethy. At the age of 21 he was made a licentiate of the Society of Apothecaries and a member of the Royal College of Surgeons. The names of the apothecaries who appear on his certificate include that of John Hunter.

Young William was the fifth born of the seven children of the Reverend William Price, sometime fellow of Jesus College, Oxford, who resigned his fellowship on abandoning his celibacy and marrying Mary Edmunds of Machen, an illiterate maid-servant. Yet this woman much below him in station in life looked after the Rev William and his seven children: for he could

not. Among the eccentricities of the father was a great predilection for water. One of his greatest enjoyments was to immerse himself in a pond up to his neck. Sometimes he would take off his clothes before going in to the water. But before he put them on again he would be sure to dip them in the pond to make them wet. If he went in without his hat on, he would not neglect to fill it with water before he replaced it on his head.

After the Rev William's death a dispute arose about his competence in managing his affairs. This entailed examination for the surprising purpose of showing that he was not *compos mentis* at the relevant time. Necropsy examination revealed that the blood vessels of the brain were very large, and it was solemnly suggested that his desire to immerse himself in water, was in order to relieve their throbbing. Dr William Price claimed that it was he who had performed the necropsy examination.

Many of the stories are apocryphal. Such as the one that Dr Price had grafted a calf's bone to repair a collier's compound fracture. "Did you know that Dr Price once cured a patient's stomach ache by making him vomit into a bucket and taking a live frog out of it?" He did really defeat an extravagantly mulled lady complaining of headache by advising her to decrease the weight of thanks to relieve the load? And was an old farmer "stiff as an old horse" told to wash and remove the weight of dirt?

There were commonsense diagnoses and cures concerning patients suffering from overindulgence in food and drink. They were told that their troubles were due to "consumption." "Tale consumption of the most hopeless kind. No cure unless you live lower and eat less." He seems to have anticipated modern practice by regarding smoking as a dangerous and disgusting habit, and indeed was wont to refuse treatment unless the patient promised first to give it up. On 17 April 1940 Mr James Powell of Swansea wrote to the *Western Mail* that he had once travelled with Dr Price by train from Pontypridd to Merthyr. Dr Price asked a fellow traveller to stop smoking. The fellow passenger refused. Whereupon Dr Price threw his pipe out of the

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Pathology of Partnerships

You're never here . . . I'm never there

GEMINI

You're never here . . .

The major causes of interpartnership strife are money and work load. Time, it is said, is money, and this is certainly true in the general practice. Our senior partner is never here so we got him to analyse his diary for 1981 to find out what he does all the time. Two days a week he is out of the practice as a part-time academic in general practice at a nearby medical school. During the past year, excluding evening talks to local organisations in the practice area, he gave 32 lectures at home and abroad. In addition to a week in another continent he spent 21 days on six medical visits to Europe. He assisted in the making of television productions for undergraduate and postgraduate teaching with universities, the BBC, and Independent Television producers. He wrote 37 articles of between 300 and 10 000 words for the medical press. He examined or assessed for two universities and for the Royal College of General Practitioners, which required many hours of reading and marking papers and attending oral and examiners' workshops. In addition, he took two weeks holiday and a few days off to attend to the affairs of a deceased relative.

This man receives 30% of the profits of a four-man practice. How can this be?

Of course it did not happen suddenly. Over the years partners in the practice have taken time off for professional activities outside the practice such as clinical assistantships. The practice has always recognised the value of such posts since they have brought new experience, knowledge, and skills to enrich the partnership. The partners also established the principle that by putting into the practice the income from this extra work the absent partner paid for the time he took out. This principle has thus been extended to our present senior partner. He earns some £9000 from his university appointment. In 1981 his examining, lecturing, and writing brought in some £4000. In addition he maintains all his normal National Health Service income for the practice since he works a minimum of 25 hours a week in the practice, excluding his nights on duty and a one-in-four weekend rota. By agreement, the only monies the partners retain for themselves are seniority and vocational training awards. So our senior partner brings in £13 000 over and above his normal remuneration, though, of course, he misses some extra item-of-service payments because of his reduced time. In return for this increased practice income we have had some difficulties in defining the amount of time he may take. Each partner is permitted six weeks annual leave, of which two weeks must be spent on some form of educational activity. This entitlement is clearly spelt out in the partnership agreement. Because of the senior partner's commitment to his academic appointment he is also allowed a maximum of 100 days out of the practice per year in addition to his six weeks leave, and this too is clearly laid down in the agreement. We have also agreed that each partner may take sabbatical leave up to six months every seven years, during which he retains his practice income but provides a locum at his own expense. This in effect allows our senior partner to buy time for his

activities outside the practice. The work that he does not do during this time is of course divided among the other three partners who receive part of the £13 000 extra income in proportion to their partnership shares. One is reminded of Aneurin Bevan's stinging of complaint by "snuffing mouths with gold." It is not the whole answer, but it certainly helps quell our cry of "You're never here."

Interestingly our academic partner's advice was sought by a disgruntled member of another practice who aggrieved that his practice had suggested he paid into the practice the fees resulting from his growing amount of writing. Our old man sometimes feels a little sore that so much work done in his own time should enrich the practice, but in the long run the cost of buying the time which enables him to have so varied a life in medicine is relatively cheap.

The other aspect of this absence—its effect on continuity of care and the guilt the doctor feels is another story . . .

. . . I'm never there

The trouble with me is I'm never there! Like an increasing number of general practitioners I have a part-time job that keeps me away from the practice. Some of us work in the hospital but, in a way, that is rather different from those of us who are not doing a purely clinical task outside but are teaching or doing research or administrative or organisational tasks, or maybe a combination of all three.

I have partners who rarely complain about me—at least not openly. They readily accept the need for someone to do the other job and, provided it is arranged in a way that does not work that they are not being adequately paid for, there are no complaints.

There are two major problems that I have run up against: the first is the sheer difficulties of organisation. The time spent in running my two jobs are quite different. My work in the practice requires continuity of care and some predictability which I just don't seem to be able to provide. Many times I see a patient who is looking at several days in a row. Often it is an acutely ill or seriously ill, even dying, patient of long standing. In such cases continuity of care is most important. Sometimes I will admit a patient to one of the general practitioner beds that I am responsible for, say, 4 am, and the next day I am away. There are no housemen or registrars to cover.

The time scale of my other post is rigid and fixed for weeks or months ahead. Meetings to chair or attend, lectures to give, visits to make, visitors to receive—these are not tasks that can be dropped at short notice.

My solution to the problem is to share the care of some patients with one of my partners. It is made easy by having partners whose clinical judgment can be trusted, and perhaps that is why I have always placed that first on my list of desirable attributes for a new partner. Apart from this, however, other steps have to be taken that are desirable in any practice but become essential in "shared" care. Notes must be kept

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Dr William Price in his suit of scarlet merino wool with green silk lacing. This photograph appears as the frontispiece of his extraordinary *Gwyltill yn Noyd*, published in 1871: this is Prician Welsh for *The Will of My Father*. It is written throughout in the curious spelling that Price claimed was old Welsh. In one hand he holds a staff with the crescent moon, which he described as *ceffwr y bardd*, and in the other the mandorla *egg*, or the emblem of immortality. *Gwyltill yn Noyd* seems to finish with a reference to this suit of "rights," which his daughter Penelope likened to a lady's combinations. It may be translated as:

Pure Welsh is the copy of the will of the chief bard of the learning of Wales from his old egg which you see on my clothing, and his

hand in my left hand and in the will of the father of us Welsh, as it has been spelt [written] in the Welsh of the Royal Province by him more than two thousand and six hundred years ago, and here it is, and a copy of his form singing it on the next page.

in his personal hygiene he was obsessively clean. Each day he wore a clean white tunic, freshly hand-washed by his mistress Gwennellin Llewellyn. After receiving a fee, he always washed the coins before putting them in his pocket and then washed his hands. The doctor was a keen walker and whenever possible did his visits on foot. Perhaps therefore considered attention should be paid to his opinion that it was injurious to health to wear socks. These garments Dr Price himself personally eschewed, and it is a pity that they were thus denied the benefit of his sartorial ingenuity. He claimed that "stockings prevent the proper exhalation of the feet, which in consequence are kept cold. Thus the person who wears them is more likely to catch cold. My feet are always dry and warm." In visiting Pontypridd

from Llantrisant he always walked and never took those short cuts which wasted time by climbing over stile, as he preferred "to keep up a steady pace."

He was known to visit whenever possible during the hours of darkness, his theory being that patients felt at their worst during the night and therefore needed more attention than during the daytime. For a similar reason Dr Price had no watch, which he said was not needed as the time to see patients was when they sent for you. His political life was just as colourful. The Chartist of the 1830s were divided into moral and physical force groups. Price must have belonged to the latter for he claimed that he was to have produced seven cannon for the march on Newport. In the event neither he nor they ever arrived. Though, of course, the march itself did take place and unfortunately ended in loss of life during the fracas at the Westgate Hotel.

There simply is not space to recount the many episodes that filled his long life. We shall have to be content with the dramatic climax that was to lead to his trial that established the legality of cremation, though nothing was farther from his mind when on that Sunday evening of 13 January 1884 the people of Llantrisant saw the first lighting on Caerlon Hill. Many were returning from chapel and their excitement was increased by their certainty that Dr William Price, on whose land the fire burned, was providing some new chapter in the pagentry which had not been dimmed by his advanced years. The strange lonely figure of the doctor clad in a white robe, his long white hair and beard flowing in the wind, stood in the uncanny light, his arms outstretched as if on a crucifix. He could be heard chanting ancient Welsh poetry through the flames and the surrounding darkness. The doctor was burning a body. Thoughts of his well known druidic beliefs and the association of that cult with human sacrifice swept away the affectionate good humour that had indulged his eccentricities. Although not understanding his ways, the villagers felt that his reputation for miraculous cures, his distastes on learning, and the mysteries of his ceremonies had earned him their respect, not unmixed with fear. All the village knew that a child of about five months, strangely if not blasphemously named Iesu Grist Price had died in the doctor's house at about 10 o'clock on Thursday night. Iesu may be an acceptable name in popish Spanish places, but Iesu Grist Price was totally unacceptable in nonconformist Wales. If what was now being seen and heard was not actually human sacrifice, at best it could only be desecration of the dead. For Price was indeed burning the dead body of his infant child, fathered on his young mistress at his age of 83. There were two later children of the union. (His daughter Penelope died only a few years ago.) The crowd interfered and the doctor had to be saved by the police—though he strenuously denied the charges.

The case of Regina v Price was heard at the Glamorganshire Winter Assizes of 1884 before Mr Justice Stephen. The legal points decided by the trial were: "To burn a dead body instead of burying it, is not a misdemeanour unless it is done as an amount to a public nuisance," and "If an inquest ought to be held on a dead body, it is a misdemeanour so to dispose of the body so as to prevent the coroner from holding the inquest." After a trial in which Price lived up to his name, the editor of *The South Wales Daily News* commented that although he had been found not guilty, he had been told not to do it again. On 14 March 1884 Price removed the baby's body from beneath his bed, where it had lain since he had recovered it after the coroner's inquest, and quietly finished the task of burning Iesu Grist Price with a half ton of coal, a gallon of paraffin oil, and sixpennyworth of wood. The *British Medical Journal* reported that the total cost was 5s 2d.