PRACTICE OBSERVED

Interesting GPs of the Past

A J Macleod of North Uist

KENNETH MACRAE LEIGHTON

A J Macleod, "Zadok" since his Lewis boyhood, had been in North Uist for 16 years when I went with Donald Munro to do his locum in 1948. He was already famous in the Highlands and Islands Medical Service and the fledgling NHS was just beginning to get the measure of the man.

It was a memorable locum for two housemen from Aberdeen. Much of it is now a blur of magnificent and gargantuan island meals (for the mainland was much rationed at the time), compounded with peat smoke, hospitality, and some hair-raising anxiety. Macleod left us hurriedly and returned early and unannounced. Both were disconcerting, but we must have passed the test for he offered us jobs when National Service was over. To my great fortune I was in a position to accept, and I returned to Lochmaddy as a "live in" assistant.

Zadok was but the second doctor ever to practise on North Uist, replacing the legendary Mackenzie of Scapaig who looked after the last epidemic of typhus in Britain and included isolated St Kilda in his practice. Zadok was proud to come over from his first practice in Applecross to succeed Mackenzie in 1932. He was a big man, made larger by his tweeds. He wore plus-fours (or perhaps plus-two-and-a-halfs) and was seldom seen in anything else except when he went to the annual general meeting of the BMA, when he often wore the Highland dress. It was an eminently practical garb for walking over heather and peat and wading burns and shallow tides, and we did a lot of this for, although there was a perimeter road, many places could be reached only by overland trek. It was a grand life.

I can see him now, waiting for me on the shore at Carinish when I first arrived by boat from Benbecula and my plane from the mainland for my first meeting with him and my introduction to the island and the real world of medicine. It was a bright sunny Hebridean day and the wind was ruffling his sparse hair

like the bog-cotton in the peat behind him. He had a curious way of looking at you, and until you knew that he had lost an eye at thirty while a student at Glasgow you might think he was looking in disapproval. I had never treated a patient who wasn't lying in a hospital bed and I was nervous enough. Thank God, though, the fates were kind that day, and we stepped off together on the right foot and never looked back. My enrolment in the Lochmaddy School of Postgraduate Medicine started that day—as well as a life-long friendship.

Hebridean practices differ from those on the mainland in many ways. The Minch, for instance, can be quite a barrier, and Atlantic gales can interrupt sea and air traffic alike. During my time with Zadok we were frequently isolated from orthodox communication with the mainland though there was always the

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Dr Macleod rising back from Loch Portan

Scottish Air Ambulance and the redoubtable Captain Barclay, who would try to reach us in the foulest weather to land on beach or machair and take off again just inches ahead of an advancing tide. Nevertheless, it was an isolated practice, even at the best of times. We had three beds in the hospice in Lochmaddy to take the most difficult midwifery, and above all we had the services of the magnificent Queen's Nurses, scattered around the island. We could not have managed without them.

Here, Zadok was magnificent and he was king. We held surgery hours every morning after breakfast when the dishes had been removed from the table. The dining-room doubled as the waiting room, and early arrivals were sometimes asked to join us in a cup of tea. Otherwise they hung around outside the door, huddled against the gale and worried—if not

savaged—by Turk, a black Labrador with an uncertain disposition. The surgery would deserve a book to itself. A large stuffed swan sat either in the hearth or on top of the pile of records, reports, and journals that filled the old roll-top desk. There must have been a chair for the patients, for we used to extract teeth and I can't believe that we did this when they were standing up. There was little free space amid the conglomeration of Winchester flasks, fishing rods, first-aid boxes, folding canvas stretchers, and implements for minor surgery that filled up most of the room.

When the weather was cold there was a fire—that was when the swan was moved from the hearth. Burning or not, the peats still gave off their distinctive aroma, which, mingled with the smell of wet tweeds, ether, surgical spirit, and mist expect stim, I retain forever in my hippocampal gyrus or thereby. Since we had to dispense our own prescriptions I learned very quickly how few are really necessary, even in the best of practices. And Zadok's was one of these.

He was also a good teacher, but in the bardic mould. His assistants swallowed him whole or not at all. There was the occasional one who could not discern the man from the tweed, as it were. Not everyone was ready for his form of instruction; he could be overpowering. His other dicta were sufficiently provocative to make the orthodox recoil. That was his way—an outrageous premise with anecdotal support. Then, much later, came evidence based on shrewd observation and, quite often, a remarkable familiarity with the literature. For me it was a stimulating and fascinating environment, and when added to that one could spend days on one's own visiting another island like Bernera or Grimsay, dealing with everything and everyone, I must say it was very heaven.

There was no doubt that Zadok was the uncrowned king of North Uist. To drive around the island with him was to travel with royalty. It could also be hazardous, for he was certainly the

worst driver I have known. His vision monocular, his depth perception non-existent, the rain slashing across the windscreen so forcefully that the wipers, did they work, could not keep pace with it, the car buffeted by the Atlantic gale, and Zadok, in full flood of rhetoric and anecdote, coming around a corner and suddenly spying the first Bewick swan of the year, or a red-throated diver, or worse still an oncoming vehicle, and we were in the ditch on our side, or more likely (for his luck was legendary) bouncing over the heather with Zadok crying, "Look at that, now!"

He was more at home in fact walking six miles over the moor, leaping from tussock to tussock, every pocket bulging with dressings and drugs, on his way to visit a distant croft where he would be welcomed as a friend and guest with good Gaelic, spoken still like a Lewisman and thus setting him just that necessary little bit apart from his patients, the people of Uist. They say that if you walk down Princes Street in Edinburgh you will meet everyone worth meeting, sooner or later. I used to feel the same way about the doctor's house in Lochmaddy. Our summers were filled with visitors. Scandinavians, some who had known Zadok in his Antarctic whaling days, authors, painters, and naturalists. They came in droves, and they were all interesting. More grist to the mill of the postgraduate school. We sat up half the night, and more than half the night, talking and listening. And Zadok could hold them all in the hollow of his hand. Nor were all our visitors laymen, and several islanders have had unexpected domiciliary consultations which arose out of an after dinner discussion of a puzzling case. No one escaped from the island without being pumped dry of all that he could offer.

It is impossible to describe Zadok Macleod properly without describing North Uist, and there isn't space for that. It is just as difficult to think of North Uist without Zadok. But, by a quirk of fate, good fortune, and that amazing luck that carried him through Gallipoli with the Ross Mountain Battery and saw him through his adventures with the automobile and small boats, he has been followed in the practice in Lochmaddy by his son, the Boy John. Thus has a dynasty begun.

I stayed with Zadok two years before his death. We sat up late as we had so often done before. Once more the peats burned bright, and once more he sat in his favourite chair. We relived the polio epidemic of 1951, which went like measles through the island, and we refought battles lost and won with bureaucracy. I listened again to the saga of health and sickness, the epidemiology of an island, observed by one remarkable practitioner over a span of more than 40 years.

Once again midnight came and went unheeded as we talked on into the early dawn of a clear, still Hebridean morning, and then I made my way to bed filled with the saga of North Uist and with my batteries recharged for the last time.

OF COLDS AND COUGHS.

In the bilious colic the vomiting is often very difficult to refrain. When this happens, the patient may drink a decoction of balled bread, or an infusion of garden-mint in boiling water. Should this have the desired effect, the faine draught, with a few drops of ladanum in it, may be given, and repeated according to the urgency of the symptoms. A small quantity of Venice treacle may be placed in form of a cataplane, and applied to the pit of the stomach. Clysters, with a proper quantity of Venice treacle or liquid ladanum in them, may likewise be frequently administered.

Scilla is as liable to frequent returns of the bilious colic, should it be both purgative, and live chiefly upon a light vegetable diet. They should likewise take frequently a dose of cream of tartar with tamarinds, or any other cool acid purge.

(Bach's Domestic Medicine, 1786.)

Safer Prescribing

Many a slip

MICHAEL DRURY, KARL SABBAGH

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation. Further information about the tape-slide programme on which this series is based is available from the MSD Foundation, Tavistock House, Tavistock Square, London WC1H 9LG.

Although writing a prescription may seem the simplest of acts a great many errors can be made, and very serious consequences

may result. In this article we present examples of prescriptions as given to patients. There is some information on the patient and some questions that point towards problems that may result from the prescription.

You will make best use of this article if you look at the prescription and the information on the patient before you look at the questions. Approved names of drugs are given at the end.

Patient: Miss Sara Crone. A well known neurotic patient who always brings her colds to the doctor.

Patient: Mrs Fiona Large. A woman you have treated for epilepsy since childhood and who is now seeing you for morning sickness.

CRONE

Address: 114/17

GP: N.P.

Prescription:

Tel. 10/10/81

2 tabs p.d.

h.c. 200

Swiss 4 p.m.

2 tabs

h.c. 100

Date: 2/2/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

Is the prescription legible?
Is Braddon a placebo?
If it is could a cheaper one be used?

LARGE

Address: 24/10/81

GP: N.P.

Prescription:

Phenylin 100 mg

t.d.s

m 300

Leonard H. H. H.

1 day

m 100

Date: 3/1/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

What about phenytoin in pregnancy?
Are any extra tests required for folate deficiency?

Patient: Dolly Jones. A diabetic.

Patient: Mrs Fanny Hook. A young mother who is having treatment for a "spot on the lung," and presents for a repeat prescription.

Patient: Mrs Ivy Preston. A lady of 50 with controlled hypertension who develops cystitis.

JONES

Address: 11/1/81

GP: N.P.

Prescription:

Tel. 10/10/81

2 tabs

h.c. 200

Swiss 4 p.m.

2 tabs

h.c. 100

Date: 2/2/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

What about diabetes and the pill?
Is it an absolute contraindication?
How does one affect the other and what does a diuretic do?
Is potassium supplementation necessary?

HOOKE

Address: 11/1/81

GP: N.P.

Prescription:

Rifampicin 150 mg

q.s. daily

h.c. 100

Swiss 4 p.m.

2 tabs

h.c. 100

Date: 2/2/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

What about protein binding?
Which drug is affected?

PRESTON

Address: 11/1/81

GP: N.P.

Prescription:

Trimethoprim 200 mg

q.s. daily

h.c. 100

Swiss 4 p.m.

2 tabs

h.c. 100

Date: 2/2/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

Is the length of treatment with trimethoprim necessary?
Does Inderal need to be taken three times daily?

CLOWORTHY

Address: 11/1/81

GP: N.P.

Prescription:

Aspirin 300 mg

q.s. daily

h.c. 100

Swiss 4 p.m.

2 tabs

h.c. 100

Date: 2/2/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

What about salicylates and anticoagulants?

GROUT

Address: 11/1/81

GP: N.P.

Prescription:

Aspirin 300 mg

q.s. daily

h.c. 100

Swiss 4 p.m.

2 tabs

h.c. 100

Date: 2/2/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

What about thiazide diuretics and gout?
What alternative treatment might be used?

TUSSEY

Address: 11/1/81

GP: N.P.

Prescription:

Delamir-C 150 mg

1 x 4 daily

32

Benlin 5 mls

p.m.

m 100

Date: 2/2/82

Signature: [Signature]

IMPORTANT: Read notes overleaf before going to pharmacy

Does the antibiotic carry gastrointestinal risks that are greater than the complaint warrants?

Patient: Justin Dorman. A young man with psychological problems.

SURNAME	NAME	DATE	TIME	INITIALS	REMARKS
DORMAN	Justin	17	10.00	NP	
Manserv	30 mg (100)				
Optimase	2 tabs (100)				
Normison	2 tabs (100)				
Valium	10 mg (100)				

7.1.82

IMPORTANT: Read notes on back before going to pharmacy. (100)

What do you think is going on here?
What course of action might you pursue?

Proprietary names:

Bradian nicoformate; Dalaun C chindamycin; Inderal propranolol; Marevan warfarin; Benonal benorilate; Diamide C frusemide with potassium chloride; Optimase, tryptophan, pyridoxine, and ascorbic acid; Normison, temazepam; Valium diazepam; Gentacin cream gentamicin cream.

This is the third of four articles on prescribing.

MEDICINES.—In an inflammation of the brain, nothing more certainly reduces the patient than a free discharge of blood from the nose. When this comes of its own accord, it is by no means to be stopped, but rather promoted, by applying cloths dipped in warm water to the part. When bleeding at the nose does not happen spontaneously, it may be produced, by putting a tress, or any other (flap) body up the nostril.

But even in the suppurative stages greatly relieves the head; but as this operation cannot always be performed, we would recommend in its stead bleeding in the angular veins. When the patient's pulse and spirits are low, that he cannot bear bleeding with the lancet, leeches may be applied to the temples. These not only draw off the blood more gradually, but by being applied nearer to the part affected, generally give more immediate relief.

A sty or abscess of blood from the hamorrhoidal veins is likewise of great service, and ought by all means to be promoted. If the patient has been subject to the bleeding piles, and that discharge has been stopped, every method must be tried to restore it, as the application of leeches to the parts, sitting over the steams of warm water,

Patient: Billy Spot. A boy with an infected rash.

SURNAME	NAME	DATE	TIME	INITIALS	REMARKS
SPOT	Billy	17	10.00	NP	
Levulin	10 mg (100)				
Hydrocortisone	10 mg (100)				

17.1.82

IMPORTANT: Read notes on back before going to pharmacy. (100)

What are the hazards associated with topical antibiotics?
What is the place of antiseptics?

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sharp cylinders or hypodermics made of bone, silver, and rock-fall. In the inflammation of the brain, nothing more certainly reduces the patient than a free discharge of blood from the nose. When this comes of its own accord, it is by no means to be stopped, but rather promoted, by applying cloths dipped in warm water to the part. When bleeding at the nose does not happen spontaneously, it may be produced, by putting a tress, or any other (flap) body up the nostril.

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(Bachan's Domestic Medicine, 1866)

With regard to continuity of care I would say that over a timespan of two years one naturally collects one's own list of patients, and it can easily be arranged that they attend on days when one is working at the practice and their day-to-day problems dealt with adequately. This also applies to regular home visits. In fact I would say that in two years as a part-time one almost becomes a permanent feature of the practice and, apart from obvious immaturity in the ways of general practice, much more akin to a partner than any full-time trainee who knows and whom the patient knows will move on after a year. Admittedly, there are times when things at home become demanding—for example, when a child falls ill. When this happened to me I took a holiday allowance at short notice. It did cause some inconvenience, but my trainee was kind and understanding. There will be some lack of continuity of care, particularly if a problem takes several days to manage,

for example in committing a psychotic patient. But I believe that there is a place for the part-time trainee and that it is an ideal opportunity for women to complete vocational training, thus justifying a place in medicine, while at the same time rearing a family.

Considering my advantages in having an excellent trainer, working in a well-run family practice, having a reliable child-minder, and relatives near, not to mention financial reward, there is no reason for me to labour the difficulties of being a working mother. Compared to some I had it easy. For me it has been a freedom to be able to work as a trainee in general practice to gain my independence as a fully-qualified practitioner.

Perhaps I was lucky and my experience may not be representative. As the reader will have gathered, the success of the job turned on the personality of my principal—he was always available and made me feel that I was one of the team.

Organising a Practice

Practising from purpose-built premises

N H BARLEY

In 1954 three of the present partnership of six doctors were practising together in Merton Park, a typical London suburb, from a large old house that had been used as a surgery since well into the last century. It was rented from the heirs of the practice originator. The list size in 1954 was about 6000 patients, and the accommodation was quite adequate for medical practice as it was then.

In 1960 the local authority told us that the house would fairly soon be demolished for road widening. Readers will not be surprised to learn that the house still stands and the road remains unwidened. At about this time the owners offered the house for sale, and as it had a long garden we planned not only to buy the existing house but also to erect new purpose-built practice accommodation at the bottom of the garden. This would be well clear of any road-widening.

Scheme 1

In 1960 the Surrey and South-west London Executive Council agreed to finance the development of the new surgery under the interest-free loan scheme then operating. We also received a grant, based on the number of partners, towards the cost of building. An architect was appointed and an attractive building costing £7900 was erected.

This new building provided the following accommodation: three consulting rooms, one with its own examination room; and the other two sharing an examination room; a nurse's treatment room; an attractive kidney-shaped waiting area—while this shape appealed to the architect it is not very practical for consulting rooms.

Merton Park, London SW19 3N

N H BARLEY, MB, MRCP, general practitioner

—which also had a central open area with a fish pond to amuse the junior patients; office and records accommodation; and a three-bedroom caretaker's flat, which subsequently proved to be extremely valuable. At that time the only ancillary help employed in the practice other than a cleaner was two receptionists, one of whom, the morning receptionist, doubled as a typist.

In 1961 we moved into our new accommodation, which for us was a very attractive environment. It was also quite adequate except that we quickly discovered our mistake in providing only one examination room for two consulting rooms. The Executive Council deducted £100 per doctor per year in capital repayments and there were no reimbursements in rent since the loan was interest free, and any interest reimbursement was regarded as interest payment on the loan. This was very satisfactory in the relatively inflation-free days of 1961 but would be quite inappropriate today.

Scheme 2

By 1965 the practice had grown sufficiently to require a fourth partner. In addition, our first health visitor had been attached to the practice, and we had also pioneered the attachment of a district nurse—the first such attachment in our area. Clearly the time had arrived when we needed more practice accommodation.

A scheme was drawn up to increase the number of consulting rooms to four, giving each consulting room its own examination room. We also took the opportunity to include a small common room in which we could meet the attached staff. At this time we also secured the kidney-shaped waiting area to enlarge the waiting space, sacrificing a marginally more attractive shape in the process. The cost of this expansion was £6000, which was financed by each of the four partners borrowing £1500 from an insurance company. We first got an assurance from

Women in General Practice

GILLIAN JEBB

During my short medical career I have met many people who feel that sought-after places in medical school have been wasted on women, who, because of enforced absence from medicine for family reasons, would not serve the community with service given to the community. I argue that women, despite their obvious biological differences, are as capable as men of hard work and of making a contribution to medicine.

After my pre-registration year and after completing two and a half years as senior house officer in various specialties, which included general medicine, obstetrics and gynaecology, paediatrics, and psychiatry, I left medicine to look after my first child. I was glad of the break. Everyone is different. Not everyone regards medicine as a vocation or a way of life, some regard it as a not too disagreeable way of earning a living. I thought that being at home would satisfy me. It was not until I had been away from medicine several months that I realised how much I missed it. By "it" I mean everything associated with patient care, contact with colleagues, and the bustle of hospital life. This implies, I suppose, that medicine—for me at least—is a vocation.

Part-time trainee

I decided to look for part-time employment, and since I had completed my own freelance vocational training in hospitals it seemed a good idea to seek out a part-time traineeship in general practice. It was not easy to find a part-time traineeship. Had I the sense to contact the regional adviser in the first place I would not have spent so much time approaching doctors who had no need of—and, indeed, were unaware of the existence of—part-time trainees. When I did contact the regional adviser a post was found for me immediately. I was fortunate to be accepted by the senior partner in a well-established family practice in the south of Birmingham. There were three full-time and one "minimum full-time" partners who looked after a stable population of 2000 patients. There was excellent liaison with local hospitals and "open access" for all necessary investigations. Ancillary staff included a practice manager and a part-time State-registered nurse trained in family planning, and shared attached staff included district nurses, a district midwife, a domiciliary physiotherapist, and a dietitian. This is the bare bones. The strength of the practice arose from its close unforced relationships and the quality of the practice manager and reception staff, who worked as a team and were invariably kind and helpful.

When I started my traineeship in May 1980 I had a little girl aged 8 months. My husband was completing his hospital training posts. Despite my previous medical experience and my short absence from medicine, my confidence was shaky and I was ill at ease in consultations. Again I was fortunate to have a trainer who, through long experience, recognised my condition. Together we organised my work. It was decided that I should complete my five sessions in two and a half days, which allowed a four-day stretch at home with my family. Of the five sessions, three were spent doing surgeries at the practice. One

session was allocated to the weekly trainee course meeting and a further session for attendance at an outpatient clinic of my choice.

Happily, my trainer's enlightened approach to the traineeship was that I was there to learn and that I should take every opportunity to cover gaps in my medical training and knowledge. One way of doing this was to attend various outpatient clinics with the consent of the consultant concerned. In this way I learnt something of ophthalmology and ENT, both of which had been scantily dealt with in my student years. I also attended chest and venereal disease clinics and rheumatology, dermatology, and medical outpatients. People were happy to allow me to sit in at consultations. Although I found attendance at clinics most helpful, I feel there is nothing to compare with the direct doctor-patient consultation. A variety of clinics were held in the practice—well-baby, antenatal, and family planning clinics. There were also clinics for diabetic and hypertensive patients in which I participated. There was a wealth of opportunity for me to learn.

Having lunch once a week with my trainer was regarded as an integral part of my training. This was a pleasant and informal prelude to an equally relaxed and informal tutorial. I was also included on the rota for nights and weekends. The partners employed the deputising service only to receive and transmit calls to the doctor "on duty" via a bleep system. The occasional night didn't bother me—in fact I enjoyed them—but the weekends upset my daughter, who never quite became accustomed to her mother rushing in and out of the house. I invariably shut the door on a screaming angry child as I zoomed off to attend the supposed emergency—quite often another screaming infant. There were also the unfortunate and rare occasions when my husband and I were on call at the same time; my daughter was then packed off to her grandparents for the weekend. Overall the arrangement of my working week suited me well.

The case for part-time work

Many people believe that part-time work in general practice is of little value and leads to a lack of continuity of care, thus making difficulties for both patients and doctors. The patient may be forced to consult more than one doctor for one problem. The doctor may be called upon to tie up someone else's loose ends. Furthermore, the part-time doctor, who is usually a married woman, may not be able to concentrate on the task at hand, finding that her mind wanders to her domestic life and all its attendant demands. The beauty of part-time employment is that, given an understanding boss and a degree of flexibility, there are many ways of organising the working week to deal with that. The work can be arranged around other commitments to suit oneself. There should therefore be no excuse for a half-hearted approach. The necessary session may be spread over the week or concentrated over a few days. I chose the latter for the very reason that it was less distracting. Without deadlines to meet during the day I could work at my own pace, tackle problems in my own way, and generally live with an easy mind. Of course this could not have been accomplished without an excellent child-minder. Child-minders are a remarkable breed (at least those I have known have been remarkable) who, for a pitance, look after other people's children and allow the mother freedom to go to work.

the district valuer that the increased rent from the increased accommodation would cover the costs of the interest payments made to the insurance company on the loan. The capital was to be repaid by a linked 15-year term endowment insurance policy. The new arrangements worked well so long as there were only four partners, except that the commonroom was too small for full practice meetings to take place. By 1970 the need for a caretaker had disappeared, and at a very small cost the maisonette accommodation was incorporated into the practice.

Scheme 3

The cost of this conversion was less than £1000 and was borne out of the then current practice income. This enabled us to have a larger and more satisfactory commonroom and to increase the number of consulting suites to five consulting and examination rooms. It also allowed us to enlarge the office accommodation for storage of the increasing number of records. By this time we were also employing a practice manager, and the expansion provided her with a small office, together with some modest office accommodation for our two attached health visitors. It was envisaged that for personal interviews the health visitors would also be able to use the doctors' consulting rooms. By 1975 the practice amalgamated with an adjoining one, giving a total list size of 15 000 patients. There are now six partners, three health visitors—two of whom are field-work instructors with occasional students, four community nurses, two practice nurses, an attached social worker, a trainee doctor, and full supporting administrative staff, together with facilities for teaching undergraduate medical students. Midwives also attend our antenatal clinic. By 1975 the practice was also running its own infant welfare and developmental clinics and a whole range of other services requiring more space. So further expansion was necessary.

Scheme 4

In this scheme we added a room 25 feet by 17 feet, which would be used as a commonroom, seminar room, health education area, and would provide much-needed space for full developmental checks on children. In addition, it was sufficiently large for carrying out eye tests without the use of mirrors. Attached to this room was a new kitchen. The opportunity was taken to enlarge the records office, to double the size of the treatment room, and to build a new nurse's office. At this time the open area in the waiting room was roofed over to make the space usable as an appointments and reception desk. We were sad to see the small garden disappear, but another one had been created in scheme 2. The cost of this development was £15 000. Since we already owed money to the family practitioner

committee (£3000 remaining) and to the insurance company (£6000), we decided to approach the bank, not only for the £15 000 for the new development but also for the remaining £6000 in order to tidy up the finances and to enable us to obtain the full rent reimbursement.

The cost-rent scheme was not at that time in operation so before spending the £15 000 we showed our plans to the district valuer in order to get in advance assurance that the rent increase we would receive as a result of the enlargement would at least cover the interest payments on the extra £15 000. The district valuer's assessment was favourable, and the bank agreed to our scheme. The result was that over the five years between 1976 and 1981 the rent received not only covered the interest payments to the bank but enabled us to pay off the whole £24 000 capital borrowed.

Conclusions

Our experience has persuaded us that purpose-built doctor-owned accommodation is an ideal solution to the problems of practice premises. It has the advantage over rented health centre accommodation or accommodation rented from the General Practice Finance Corporation that alterations can be carried out at any time to suit the practice. With careful planning and the movement of inflation over several years the rent reimbursement can be made to service the capital borrowed and to repay it as well as at no additional cost to the practice. A substantial capital investment can then be built up by the partners, thereby giving increased financial security. Unforeseen developments—in our case, the increase in the number of partners and the attachment of many more area health authority staff—can be easily accommodated. The cheapest and easiest way of financing such a development is through the practice bank.

The district valuer should be brought in early at the planning stage to ensure that the cost-rent reimbursement is not artificially high, otherwise it may be many years before the true rent catches up with the cost-rent, thereby delaying the onset of capital repayments. It is important that the district valuer assesses the premises as business premises and makes comparisons with newly erected office accommodation in the area rather than with the domestic house market. Experience leads us to believe that a practice will eventually require more accommodation than was originally planned, and GPs embarking on such schemes should bear this in mind when planning their premises. We were, incidentally, fortunate that one of the partners had sufficient knowledge of building works to enable him to draw up plans meeting the requirements of the planning and buildings regulations when extensions became practicable. Few partnerships will be in this position so they should make sure of obtaining expert advice throughout.

OF A SCIRRHUS AND CANCER.

A SCIRRHUS is a hard indurated tumour seated in some of the glands, or the breasts, the arm-pits, &c. If the tumour becomes large, unsightly, or a livid, blackish or bloody colour, and is attended with violent pain, it gets the name of an *abscess*. When the skin is broken, and a *fistula* or *scirrhus* matter of an abominable stink is discharged from the sore, it is called an *open* or *ulcerated* cancer. Before the age of 40, particularly women, and those who lead an indolent life, are most liable to this disease.

CAUSES.—This disease is often owing to suppressed evacuations; hence it proceeds frequently, fatal to women of a gross habit, particularly if cold and sallow, about the time when the menstrual flux

ceases. It may likewise be occasioned by excessive grief, fear, anger, religious melancholy, or any of the depressing passions. Hence the unfortunate, the chaste, and those persons who devote themselves to a religious life in convents or monasteries, are often afflicted with it. It may also be occasioned by the long-continued use of food that is too hard of digestion, or of an acid nature, by barrenness, celibacy, indolence, cold, blows, friction, profligate or the like. Women often suffer from the fall of the clots of their days, which liquefy and compels their breast to be so occasion great mischief. Sometimes the disease is owing to an hereditary disposition.

(Bachan's Domestic Medicine, 1866)

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