PRACTICE OBSERVED

A Difficult Case

Does it help to know your patient?

ALASTAIR F WRIGHT

Muriel

Muriel was frequently on my doorstep. She had settled in the town with her second husband after the divorce which had given her custody of the two little boys. Her second marriage seemed no happier than the first and she sought solace in my consulting room recounting her woes and heaping blame on her new partner. She herself suffered a bewildering variety of physical symptoms in addition to her "tension."

I pitied the children most. On them descended the full force of maternal hyperactivity. They were frequently brought before the doctor "peaky," out of sorts, pale, or catarrhal and had to be protected from overreaction of minor or non-existent illness.

The third pivot of this eternally troubled triangle was grandma. Mrs A, with her husband, had come to settle a few streets away, "to be near Muriel." A grey haired, plump little woman and a self confessed worrier, she had a kind heart and was popular in the neighbourhood. I saw her somewhat less often than Muriel, though I found these consultations also difficult and unsatisfying. Always excited in the presence of authority, she would talk incessantly with the persistent twittering and restless energy of a pet budgerigar.

In 10 minutes it was not easy to get a coherent version of her complaints, but invariably the main source of her anxiety was worry over her daughter's behaviour and the fate of her two little grandsons. Her excitement was usually such that she rarely heard the advice I was able to give. Presumably she derived some comfort from the release of tensions afforded by the consultation.

By early autumn 1971 I became vaguely aware of a change in

the content of our consultations. She worried and erupted as before but lately her appetite had suffered and she found her food tasteless. By instinct rather than logic or reason I became uneasy and remembered the old repeated warning of my student days in surgery "anorexia may be the only symptom of stomach cancer while it is still treatable." I found nothing on examination of her obese abdomen, and blood counts and erythrocyte sedimentation rate were normal.

Rather apologetically I referred her to an excellent and thorough consultant physician. My letter expressed my unease and my negative findings and also sketched in the social and family background. I added that "a factor in this lady's symptomatology is her inability to accept her daughter's emotional and marriage problems."

Dupont's barium meal examination showed loss of motility and was suggestive of early carcinoma. Mrs A was quickly admitted for intensive investigation. Follow up barium meal and gastroscopy failed to confirm the diagnosis of gastric carcinoma. The carefully detailed discharge report concluded: "I think her symptoms are related to her emotional problems. We are happy that she does not suffer from gastric neoplasm. Investigations have been taken to their logical conclusion and no follow up has been arranged."

Thus fortified, I quashed my original unease and reassured her strongly and perhaps less sympathetically than I might have. Life went on as before, and I continued to see Muriel and the boys with unshakable regularity. Grandma had moved from the centre of the stage and was seen less often. Her main complaints still stemmed from worry over her daughter and grandchildren rather than her own health.

Eighteen months later Mrs A began to show evidence of weight loss. I was spurred into action by a call from her anxious husband, who had previously observed a strict neutrality over the doings of his wife and her daughter and Mr B because of medical. Unfortunately, Mrs A now looked ill and her abdomen had the sinister feel of ascites with a palpable liver edge. I arranged urgent referral. Before she could be seen her

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First Five Years in Practice: the 1970s

Shaping the whole working life

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It was all so much easier then, and it wasn't just that I was younger and more energetic. The job was somehow less complicated and hence simpler to encompass in one's mind. That sort of statement, which puzzled me until quite recently, is akin to the one made by experienced doctors to the effect that the older they get the less often they are able to make a precise diagnosis. It's as though increasing time in the job makes details more fuzzy instead of more clear.

Certainly, in the summer of 1972 it all seemed beautifully clear. With a handful of others in Ipswich, and slightly more in Newcastle and Manchester, I rolled off the vocational training production line as a brand new model. There had of course been the pioneer efforts in Wessex, Inverness, and elsewhere, but it wasn't until these three areas put together their ideas and agreed on evaluation by the Manchester department of general practice that integrated training on any scale began. Most of us took it very seriously: course organisers of today may perhaps hardly believe that throughout our year in practice not one of us missed a single session of the day release course, which lasted from 10 am until 5 pm. We had the sense of being pioneers—a notion constantly reinforced by the particular brand of determinedly enthusiastic teaching which John Stevens of Alderbury made his own. Big name speakers were hailed from all parts of Britain to address us and to watch our group in action: we felt very special, and in numerical terms we were.

Hence, when it came to deciding where to practise my position was not that of the trainee of today facing the pressure of unemployment, an effectively compulsory membership examination of the Royal College of General Practitioners, and potential partners all too eager to lengthen the years to parity. My overriding wish, based on an idealism left over from work in Africa and on a vague feeling that I might want simply to put up my plate and work alone, was to practise in a place where doctors were in relatively short supply. I therefore wrote to the Medical Practices Committee and asked for a list of all the areas in England and Wales that were designated: it ran in those days in several pages, and I spent many evenings with family and friends deciding where I would like to practise. Town or country? North or south? A medical school nearby? What were the schools like? (My wife studied the Advisory Centre for Education's magazine *Where?* with as much assiduity as I gave to the small ads in the medical weeklies.)

In the end we discarded Ipswich itself (too far east, too small, indifferent schools) and Bristol (too far south, too many direct grant schools), and chose Sheffield. Such was the shortage of job hunters that when I wrote to the secretary of the local

medical committee and asked for names of forthcoming vacancies he at once came up with the kind of practice I wanted—two thirds urban, one third rural, two other partners, a list not overwhelmingly large, and a health centre on the drawing board. As the sole candidate for the vacancy, I was not surprised to get the job; both sides had their misgivings, none the less. My partners wondered what they were getting, and disliked this overtrained callow idealist, who wanted to do all his own night calls, investigate his patients, and reorganise the practice. For myself, I wondered if my training would ever become relevant in a place where deputising services were well high universal and consultants were either amazed (the geriatricians) or scathing (the paediatricians) if I did some investigations before referral.

Culture shock

There was certainly an element of culture shock to my unease. The training practice in Ipswich had been beautifully organised for two years, with two full time secretary-receptionists who typed all the records, and a fairly small list of patients whose problems had for the most part been worked out long before. In Sheffield there were well over 8000 patients who had been looked after by two doctors with many outside commitments, one of whom had been ill for months before I arrived. The load of unorganised illness in an area of traditional high demand and high referral produced in me an episode of almost frantic hand work.

I also began to have real trouble with my partners, and no doubt they said they were having trouble with me. The one who had been ill and on the point of retiring when I took the job decided as he recovered that he wanted to stay on as long as possible, and since I had lacked the persistence to get even the promise of a partnership agreement (another innovation) the senior partner brought great pressure on me to go, by, for instance, advertising my job vacant without telling me. My habit of scanning the small ads did not die quickly, and I was astonished to see a job which looked remarkably like the one I was doing; when I rang my partner to question him, he announced that he was just seeing what the field would be like. Once again the secretary of the local medical committee came to my rescue and found me a practice on a huge housing estate nearby with an elderly Irish doctor who wanted to pass on his single handed list to someone he knew. We went into partnership for a year, during which time we shared the total income from about 2000 patients and the medical boarding work he did. I lived on very little money, but it was a sign of my partner's generosity that he sometimes made an effort to not merely his income for that year but also his subsequent pension.

"Do what you like, but please don't touch the building this year," he said, as I told him my plans to hire staff, sort out the records, and buy equipment. It was a wise piece of advice, since it protected him from the pain of seeing alterations done to the house in which he had lived and practised for over

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condition deteriorated rapidly and persistent uncontrollable vomiting supervened. I admitted her to hospital. Two weeks later she died of "advanced classical gastric carcinoma."

Albert

Albert B was a dapper, rather fussy little man. Slim and short of stature, he held himself erect despite his 65 years and walked with a spring in his step. Retired from the public service, he and his wife had taken a house not far from the park. Albert had known little illness in his life and was rarely, if ever, seen at the surgery. The couple were childless and, perhaps because of this, were particularly devoted to one another.

It was New Year's day that I was called to see Albert. My own New Year celebration had been blighted by being on duty and my sleep had been disturbed on several occasions by tipsy party goers. I found Albert sitting erect in his armchair on one side of the fire. His wife sat opposite, red eyed and anxious. Albert had not been himself for several weeks now. His appetite had diminished and he felt tired and listless. His normal sleep pattern had been disturbed and he lacked energy. Worse, he lacked his normal "joie de vivre" and no longer enjoyed his walks in the park. Yes, he had felt depressed from time to time and he worried obsessively about his health. "Of course, he has never been ill, doctor." Most of the story came from his wife. Albert sat silent and apologetic.

"Why today?" I thought. "Could they not have come to the surgery after the holiday when I would have had his notes and where blood could be taken and investigations done?" But New Year is a time for reflection and taking stock, a time of awareness of mortality and the fleeting years. That was it. Postretirement involuntarily melancholia in a man used to responsibility and giving orders who was no longer needed. The years were skipping by and this was all made worse by the festive season when the lonely and left out take pills and drink alone.

After the holiday I had him to the surgery for a full physical check, blood count, and erythrocyte sedimentation rate. As I expected, nothing was found and I felt secure in my "positive diagnosis" of psychological "dis-ease." Confidential reassurance was needed to the patient and his wife. Albert looked somewhat relieved but Mrs B remained uneasy.

Over the next few months Albert became more and more concerned with his health and more and more introspective. He admitted no "physical" symptoms, had no pain or obvious disturbance of bodily functions, and provided no clues for specific investigation. He was simply "weak," "unwell," and "depressed" and convinced he was dying. At last he began to

lose weight and look ill. He was eventually found to have multiple metastases from a supraplural tumour, from which he died. His wife was more forgiving than perhaps I deserved and quickly came to terms with her grief.

Lessons learnt

It is occasionally possible for the experienced practitioner to make a "spot diagnosis" because he is familiar with the panorama of disease and knows the patient and his habits? Both of these patients were known to me: Mrs A because of frequent contacts with her and her daughter and Mr B because I knew him and his wife and because of the absence of professional contacts. The social circumstances of each were also known to me. In neither case were physical signs present till the advanced stage of the illness. In neither case were investigations of help, neither the simple tests I did myself nor the intensive investigations undergone by Mrs A in hospital.

Although my "hunch" about Mrs A's physical disease proved in the end correct, my conclusions drawn from the rather dramatic presentation of Albert B were quite wrong, and this wrong diagnosis delayed action. The normally important background information in my referral letter probably also distracted the consultant faced with such a poor historian as Mrs A.

As these two cases have shown, knowing the patient is not always helpful in diagnosis, especially if this psychosocial history is not correctly interpreted. In both cases, however, knowledge of the patient's background helped management and, I hope, helped sympathetic handling of the terminal stages of the illness.

The most important symptoms of serious illness are those that relate to a change in normal habits. Knowledge of our patient's lifestyle and circumstances, correctly interpreted, must surely help in the assessment of these changes. Our conclusions must, however, be cautious and our plan for action must be provisional for "The diagnosis of 'functional disease' in the sense of 'psychological' is the commonest refuge of the diagnostically desistate."

Reading

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Diary of Urban Marks: 1880-1949

The year of 1908 passed quickly on. I made no friends except Tweney the dentist who was very friendly with Davies and Evans. We occasionally had a game of bridge or solo at one of our other houses and at other times I took solitary walks on the Sands, wondering very often how soon it would be before I dared to get married. My first few months here were rather lonely. Davies and Tweney were married and I could not spend all my spare time, which was at that time money, at their houses. Broomfield Evans had his own pursuits and circle of friends and I could not cultivate him.

But the fates were evidently taking a hand in my affairs. Early in September May wrote to say that her father was extremely ill and almost immediately went to say that he had passed away. This was on 7 September. I went up to Corbridge for the funeral while John took care of the practice. When the will was read, it was found that Chapman, who had been thought to be really well off, had left

each of the girls £100 only and the business to Bob and Jack. The old lady Chapman was left £500 insurance money. There was, of course, great consternation. Sally Montgomery, the eldest daughter, was a teacher and was tending for herself. But May and Jane were at home. May had been with a French family for some years teaching English and she had no doubt but that she could get a similar situation. Jane was undecided what to do but it was obvious that she would have to find work. Leo, the youngest boy, was still a student of mining and the elder brothers agreed to keep him at college until he had taken his degree. The house at Corbridge was freehold and there was a small revenue attached to it from loads of sand which were retailed at one shilling per load. The sand was obtained from the river Tyne on which the house stood. It was agreed that she would have the old lady should keep on living at Earsfield, which was the name of the house.

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30 years, and prevented me from making hasty and ill conceived decisions. I therefore waited until he had retired to consult Dr Ruth Cammock, the only doubly qualified doctor-architect in practice at that time, who began by asking what kind of practice I was planning for. She explained that that question was the crucial one, and I found it a difficult one to answer because I had not before then put together into a coherent system the myriad small examples of good ideas and practical experiences that I had seen during my training. My ideas were, however, so heavily influenced by my training practice that I incorporated more of that than I would now want to.

In this second practice, I was enormously fortunate in the receptionist I inherited; recruited by my predecessor's wife through the window cleaner, she proved, despite a background of work no closer to general practice than being a bus conductor, to have the ideal combination of intelligence, practical wisdom, and, above all, a willingness to try new things. She gradually took over the administration of the practice and is now its efficient manager; her advice is sought by our ex-trainees much more often than mine or my partners'.

Unlearning, relearning, and learning

These first five years were just like the process which Michael Balint said must occur in his seminars: unlearning, relearning, and learning. The first was the hardest, and in failing to do it I made the most mistakes. The most difficult piece of advice to throw off was something I heard from one of my trainers: "Whenever I refer a patient to hospital, I feel a sense of failure." I had enough energy to put this aphorism into practice, but unfortunately not enough judgment to do it wisely. I would visit patients well past the point at which anything was being achieved other than the massage of my own ego, and investigate them for days when I should simply have admitted them to hospital. Other pieces of learning, though less painful, took in retrospect an awful long time to achieve. I struggled for years with repeat prescriptions until I copied a very simple idea that had appeared in the *Journal of the Royal College of General Practitioners* long before, and it wasn't until I took a part time job requiring a lot of correspondence that I learnt to love my pocket dictating machine more than a secretary with shorthand.

Diary of Urban Marks: 1880-1949

On the night of the will was read May and I had a serious talk. I pointed out that I was making a good living for one as far as I had gone on in the year, and with careful management the money should do for two. I was rather tired of my own company and sick of death of the eternal chop and steaks provided by Elizabeth. We never had a joint because so much would be wasted. If May was willing to put her legacy into the house as furniture I saw no reason why we should not marry at once. She agreed and we fixed the date for two months hence.

I had renewed my acquaintance with the Parkers and they took up with them while we were preparing the house. She came down for a few days and also stayed with them for three days before the ceremony, which took place at St David's Catholic Church on 12 November. A breakfast was held at the Metropole and this was paid for by my father. He came down to the wedding and there were also present the Parkers, Mr and Mrs de Gorn and, Father Gwydyr, who had married us. We went to London by the 11 am train and returned three days. I could not afford a longer honeymoon.

As we were on the station asked Jack Chapman who had come down to give his sister away how soon it would be before May received her money. He replied that it would be there almost as soon as

Because I was heavily trained, not just in the practice but also through an immensely detailed day release course for which I had done a great deal of reading, I was well launched into more than just the first five years of practice, and knew fairly well what to expect. I did not foresee that I would be able to practise so little obstetrics because Sheffield patients preferred to have a hospital delivery, and I had to learn that antepartum do little to cure most people who feel depressed. I also had scarcely heard of counselling, and had had less introduction than some trainees to practical team work. My days were therefore a good deal less complicated, and I was able to leave the building to start visits—having seen more patients in a good hour before I can nowadays. I spent every lunch time at home, and none in team or other meetings, and often spent a short afternoon in my garden. On the days when I started evening surgery late it was because I had too many visits to do, not because I had something medical other than the practice to attend to.

In 1983 our practice employs four partners and a trainee, a full time nurse, six administrative staff, a counsellor, and a clinical psychologist; we have attached to us four nurses, two health visitors, and our own social worker. Meetings about, but I occasionally long for apparently simpler days and remember the advice of another doctor, who pointed out that all the other people in primary care do their job whether you work in a team or not, so isn't it better to meet them regularly?

The first five years in practice are certainly as important as the first five years of life. What a doctor experiences during them will shape the rest of her working life, but it is also true that the gestation marks us for ever. In this period before birth I'm sure that it is the training practice that has more permanent influence than the half day release course or the hospital posts. Perhaps it is not impossible that we may one day have a training for general practice that is based entirely in practice, with periodic and concentrated learning in other places. Ian McWhinney described it in 1965; "it will be in our children's time, or their children's."

References

- Walker K. Repeat prescription recording in general practice. *J R Coll Gen Pract* 1971;21:788-91.
- McWhinney IR. General practice as an academic discipline. *Lancet* 1966; i:419-21.

Correction

Before and after the "appointed day"
In the article by Dr John Hewison (29 October, p 1271) the date of the "appointed day" should have read 5 July 1948.