Kwitesafe trial

(1) *Title*
A 16-week open study to investigate the effect of Kwitesafe on the control of blood pressure in patients.

(2) *Site*
In general practice.

(3) *Investigators*
Selected general practitioners.

(4) *Background*
Kwitesafe is a new antihypertensive agent with a unique effect (see enclosed literature). Trials have demonstrated effectiveness in the control of blood pressure in patients who are attending hospital as either inpatients or outpatients. It now seems logical to try the effect on patients in general practice.

(5) *Objectives*
(i) To determine the effect of giving Kwitesafe to patients with mild to moderate hypertension.
(ii) To assess the acceptability of Kwitesafe to both patient and doctor.

(6) *Patient entry*
(a) Patients of either sex aged between 30 and 70.
(b) Previously untreated patients or those whose treatment has been withdrawn two weeks before entry.

(7) *Patient definition*
All patients should have a diastolic blood pressure of between 95 and 120 mm Hg.

(8) *Concurrent treatment*
The concurrent use of other antihypertensive agents is not permitted.

(9) *Study design*
Each practitioner will recruit eight patients and will record the blood pressure on a standard form at two-week intervals over a period of 16 weeks. Drugs will be supplied to participants. At each visit the patient will be asked whether any side effects have occurred. These will be recorded.

(10) *Patient consent*
This should be obtained after a full explanation of the aims, methods, anticipated benefits, and potential hazards in accordance with the Declaration of Helsinki (attached).

Would you want to know about how much it cost, how many patients took it and for how long?

Does the information in *MIMS* give you what you need? Do you, for instance, add to or substitute existing treatment? What is the dose range? Are side effects dose-related? Are there any drug interactions?

There are many questions that might be asked about the trial. Has it been given approval by an ethical committee? What is an "open study" and what are its disadvantages? Is this trial capable of meeting its objectives? Are the criteria spelt out? What about the criteria for entry and the patient definition? Are there any exclusions—pregnant women, for example? Is two weeks a long enough period of withdrawal for previous treatment? Is it 4th or 5th phase blood pressure, standing or lying, left or right arm? What advice is given about withdrawals? Is it good enough to ask about side effects or should we be recording events that occur during treatment? Finally, is this really a trial or is it a concealed marketing exercise? Should doctors be concerned? Should doctors be paid for doing it? Why?

You may have realised that even with the information supplied from a wide variety of sources there's a lot you, and perhaps the manufacturers, still do not know about the drug.

Information on prescribing

How do you check that you are prescribing safely? Which of the following sources do you turn to for further information? You might arrange them in order of merit and note which you have used in the last month.

Audiocassettes
Consultants' recommendations
Discussions with professional colleagues
Drug company representatives
Medical societies
Unsponsored meetings at postgraduate centres
Sponsored meetings at postgraduate centres
MIMS
Non-subscription journals
Official Government publications
Other sponsored meetings
Papers and medical journals

When 200 general practitioners did a similar exercise, this is the order they came up with:

MIMS
Consultant's recommendation
Dissions with professional colleagues
Unsponsored meetings at postgraduate centres
Sponsored meetings at postgraduate centres
Papers and medical journals
Non-subscription journals
Drug company representatives
Official Government publications
Medical societies
Other sponsored meetings
Audiocassettes

But, of course, many of these sources of information are not available when you need them—in the surgery. There is no substitute for a well-developed sense of suspicion based on familiarity with the drugs and the patients who may need them.

This is the second of four articles on prescribing.

Clinical curio: human-hair paraphimosis

In Riyadh, Saudi Arabia, in 1977 I saw two small boys who had paraphimoses caused by long human hairs tightly wound several times around their penises at the coronal sulcus. The hairs produced oedema of the glans and obstructed the urinary flow. The members of the children's families were all unaware of the presence of the hair and did not know who had wound the hair, or where, or how. I was interested to see these two cases in Riyadh, in Saudi children, not only because the condition is rare, but also because I had already seen two similar cases in 1975 in Marj'uyun in Lebanon.

I am at a loss to explain the reasons behind this condition. I found no reference to similar cases, and I talked to several colleagues about it. But no one had seen, heard, or read about any such case, except Dr Marwan Hanna who recalled having once read in one of the biographies of Rasputin that Rasputin had done something similar to the Czar's son. But Dr Hanna could not recall the exact reference.

Who could do such a thing to a child? In searching for the possible culprit, the mother is the first suspect to come to mind. She may have been tired of washing diapers and sheets and may have attempted to lessen her burden by winding the hair around her son's penis. This is a distinct possibility, but three things militate against it. Firstly, maternal love, which although it may weaken in the face of adverse conditions and overwork remains a strong deterrent. Secondly, if the mother had wound the hair herself, she would be able to remove it and would not need to bring her son to the doctor unless because of oedema she could not find the hair. Thirdly, all the mothers were genuinely surprised when they saw the cause of the child's distress was a hair.

So, having excluded the mother, we have to look for another suspect. I presume that tying the penis of these children was done by some mischievous, psychopathic person out of jealousy, spite, vengeance, fear, or hate. The hair was in all cases 20 cm long and therefore probably came from a woman (unless it was from a long-bearded man like Rasputin).

I think that this condition has not been described before because the oedema is so pronounced that the hair becomes embedded in a deep groove and the doctor has great difficulty in noticing it. The treatment is simply removal of the hair: in all cases this was easy and curative. I will be interested to hear from anyone who has seen similar cases or who has any explanation as to why it should happen.—FARID SAMI HADDAD, chief of urology, Veterans Administration Medical Center, Phoenix, Arizona.

In many cases, dealing with acute sickness leads to lack of continuity of care. This is explicitly built into systems where a "duty" doctor sees unbooked patients. In other cases which doctor is seen will depend on whether the patient's own doctor has a surgery that day and the relative pressure of work for each doctor. A doctor who works faster or is less popular may see more unbooked patients. But is continuity of care less relevant when treating acute sickness than either long-term illness or preventive health, both of which may be more easily planned in advance? Our research found that the majority (61%) of patients who had been asked to see another doctor when making an appointment were willing to do so. Many qualified this willingness, however, by saying that they knew, or liked, the other partners in the practice. A further 13% were willing but only if they needed medical care urgently. The remainder were willing but dissatisfied or would prefer to wait for their own doctor. This suggests that most patients are happy to see any doctor when they need urgent medical attention but that they prefer a doctor they know. Interestingly, patients thought that the main advantage of larger group practices and health centres was that a doctor was available, if necessary, all day.

General practitioners frequently accept that urgent cases can be "fitted in" or seen at special times. Thus, the crux of the issue when evaluating an appointment system is the definition of "urgency." Who determines what is "urgent" and by what criteria? Field[8] said: "*Urgent* is clearly a subjective description and it could be argued that any patient who says he needs to be seen the same day has by definition an urgent problem." We agree that the definition of urgency should be left to the patient. This is the opposite of Cartwright and Anderson's finding that 91% of patients said that the decision about how soon they could get an appointment was made by the receptionist.[1] Receptionists are the ones who have to run the appointment system specified by the doctors in that practice. They are in the unenviable position of either bearing the brunt of negative criticism from patients who cannot get an appointment as soon as they want one, or the wrath of doctors who want to finish their surgery on time rather than having a series of patients fitted in or seen after surgery hours. The receptionist is therefore subject to conflicting pressures. If she acts more as a barrier to patients this is likely to reflect practice policy in terms of the definition of urgent and the way of dealing with urgent cases. Nearly 20% of our sample of patients thought that the receptionist was more of a barrier between them and the doctor than a help, and over a quarter said that they sometimes had to insist on having an urgent appointment when talking to the receptionist. Parents consistently mentioned more unsatisfactory experiences with receptionists. More of their contacts with the surgery were requests for a child—for example, for urgent appointments or home visits—at which times the receptionist's role in controlling access is likely to be more apparent.

A badly organised appointment system may act as a rationing device, providing a barrier to general practitioner care. But there is no evidence that this results in a reduction of trivial or unnecessary consultations. Cartwright and Anderson found that 40% of patients who usually had to wait three or more days to get an appointment said they had been put off going to see the doctor on some occasion in the last 12 months because of the need for an appointment.[1] In our study 41% of those who said that it was impossible to see their own doctor on the same day had on a previous occasion been discouraged from seeing the doctor.[1]

Making it work

The reality of appointment systems may vary from the extremes of serenity to chaotic, neither being satisfactory from the point of view of patients or doctors. In the serene surgery nothing disrupts the ordered flow of prebooked patients, who never see the doctor more than a few minutes late. The doctor's work is well ordered and predictable, and patients with appointments are happy. Frustration and anxiety, however, are likely to occur outside the surgery among patients who have difficulty getting an appointment to see a doctor. In the chaotic surgery patients are continually being fitted in even though the surgery session is already full, with the consequent problem that patients in the surgery have to wait a long time, and the doctor's work day cannot be planned effectively.

The best appointment system would allow the patient to define "urgency" but maintain predictability for the doctor—that is, let him know about how many patients are seen during any particular surgery. Unpredictability may be minimised by continually monitoring the number of patient requests for both urgent and non-urgent appointments on different days of the week. The arrangements for making appointments would need to be changed until an optimum balance was found, which itself may vary at different times of the year. Thus, the ratio of prebooked to unbooked appointment times would vary among days of the week and times of day, depending on the number of patients who wish to see a doctor urgently at each of these times—for example, there may be no, or very few, prebooked appointments for surgeries on Monday morning. Such a system will result in better organised doctors, more contented patients, less irate receptionists, and fewer patients who do not seek medical care when they think they need to because of the difficulty of obtaining appointments.

Other aspects

The potential disadvantage of not being able to see the doctor easily for acute sickness may therefore be overcome if sufficient attention is paid to organising an appointments system. But there is another disadvantage of an appointment system that cannot be dismissed: some people have difficulty in making appointments. Only 54% of households in England and Wales had a telephone in 1976,[4] and the proportion is much lower among elderly people and those in the lower social classes. The problems of telephoning for appointments when the surgery telephone is engaged for long periods, or when the receptionist asks the caller to hold on while another patient is seen to, were mentioned by several respondents. Such delays are especially frustrating for patients who have to use public call boxes to make appointments. The alternatives to public telephones are asking a neighbour to use the phone or going to the surgery to make the appointment. The difficulties for elderly patients are particularly great if they do not have a telephone. In our study only 20% of patients phoned to make an appointment themselves, compared with over 80% of the elderly who had telephones; 25% asked someone else to telephone; a third went to the surgery themselves—and so had the inconvenience of making two trips to the surgery each time they wanted to see the doctor; and one-fifth asked someone else to go to the surgery to make the appointment for them. Patients without telephones may therefore be discouraged from using general practitioners or may go to the surgery more often without an appointment.

Another disadvantage associated with appointment systems is that more practices with appointment systems have curtailed their surgery hours within the normal working day. Evening surgery finished at 6 00 pm or earlier for nearly half the patients who attended a practice with an appointment system, but this was so for only 11% of those attending practices where they waited in turn. This was reflected in the proportions who said that they usually had to take time off from work to go to the doctor—41% compared with 26%. This affects the lower income groups to a greater extent since they are more likely to lose pay by seeing the doctor during working hours.

What other aspects should we consider when evaluating appointment systems? Appointment systems themselves may influence the reasons for consultations and the types of clientele. Appointment systems may lead to a relative growth in consultation for some types of care—for example, preventive health care, long-term illness, and return visits—and a relative decrease

Organising a Practice

Do appointment systems work?

SARA ARBER, LUCIANNE SAWYER

Appointment systems in general practice are here to stay. They are one of several changes in practice organisation that have gathered momentum over the past 20 years. By 1977, 75% of practices were using appointment systems, compared with 15% in 1964.[1] Whether or not an appointment system is used is associated with the size of the practice. Our own research, based on interviews with a random sample of 1038 adults in Surrey and south-west London in 1977, showed that of doctors consulted by these patients only 38% of single-handed doctors had an appointment system, whereas 66% of doctors practising in partnerships of two or three doctors and more than 90% of larger partnerships and those in health centres had appointment systems.[2] Appointment systems formalise to some extent the contact between doctors and patients since arrangements generally have to be made in advance through a third party—the receptionist.

To have or have not?

The main advantages of an appointment system for the doctor are that the work load is spread more evenly among the days of the week and the times of the day, so that the doctor is better able to plan his or her time, and the patient's records are available in advance. The main advantages for the patient are a shorter average length of waiting at the surgery and being able to arrange visits to the doctor to fit in with other commitments. These advantages were shown by Bevan and Draper[3] and Cartwright[1] [4] and were confirmed in our research.[2] Patients whose doctors had no appointment system reported that on average they had to wait nearly half an hour—that is, twice as long as patients attending by appointment—and nearly a third waited three-quarters of an hour or more compared with only 10% of patients with an appointment. Patients who attended practices with appointment systems were generally in favour of them: less than 20% thought that they had no advantages; 60% thought that the main advantage was shortened waiting time; and 10% said that the advantage was being able to plan appointments in advance. But about half of the patients who attended practices without appointment systems thought that appointment systems had no advantages.

A third of the patients who attended practices with appointment systems thought that a major disadvantage was that the patient may not be able to see the doctor when he or she wants to or needs to.[2] An appointment system "is all right if you know you're going to be ill in two days time." How a practice deals with this will bear on the advantages of an appointment system.

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Appointment systems in general practice cannot be run the same way as those in other walks of life—for example, to see a bank manager, a school teacher, or a hairdresser—simply because by definition the person with an acute illness cannot plan in advance to be ill. Once a decision to consult is made the patient generally wants to see the doctor as soon as possible. Two things are needed: flexibility in the way the system is organised and a minimum time-lag between requesting an appointment and getting one. There is evidence, however, of severe problems, which affect from a third to a half of patients. Cartwright and Anderson[1] found that 63% of patients said that they could usually get an appointment within 24 hours when they wanted to see their doctor at the surgery as soon as possible, but 15% said that it usually took three days or more. When we asked patients how easy it was for them to see their own doctor at the surgery on the same day more than half said it was a problem: fairly difficult 25%, very difficult 22%, impossible 9%.[2] This suggests that in a great many practices it is a problem to see the doctor in cases of acute illness.

Types of appointment systems

Appointment systems are sometimes discussed as though everyone understands exactly what they mean, yet, as with other aspects of general practice, there are many different ways to organise them. Therefore, before one can assess the advantages or disadvantages of appointment systems it is worth discussing the types of appointment systems. There are four dimensions that need to be considered when assessing how well appointment systems are organised to deal with acute illness.

(1) The method of organisation. Consultations may be arranged (*a*) all by appointment; (*b*) some by appointment and some by "waiting in turn"—a partial system; (*c*) none by appointment.

(2) The method of coping with patients who do not have an appointment but who wish to see the doctor as soon as possible. The main alternatives are: (*a*) the patient is given the next available appointment; (*b*) a proportion of appointments are left free, to be filled only by patients requesting an appointment that day; (*c*) the patient is "fitted in" between scheduled appointments; (*d*) the patient is seen at the beginning or the end of surgery; (*e*) the patient is seen by one specific (duty) doctor.

(3) The criteria on which a decision is based if patients can be seen before the next available appointment. Here the most restrictive criterion may be only "medical emergencies" and the least restrictive for "any condition." A rough continuum might be: (*a*) medical emergency; (*b*) patient in severe pain; (*c*) worrying symptoms—anxiety about cause or prognosis; (*d*) patient in some pain; (*e*) condition would benefit from early treatment; (*f*) any condition.

(4) Who makes the decision that patients with a particular condition should be seen early? (*a*) The patient; (*b*) the doctor; (*c*) the nurse; (*d*) the receptionist or secretary.

These issues are rarely discussed in general practice yet are crucial in assessing the adequacy of appointment systems.

in consultations for acute sickness or for conditions that can only be adequately dealt with that day. When appointment systems are badly organised more people may cope on their own with short-term, self-limiting illnesses because of the feeling that by the time they get an appointment to see the doctor in two or three days the condition will have cleared up. The findings of Morrell and Kasap,[7] though based on a study of only one practice before and after an appointment system was introduced, support the thesis that appointment systems benefit those with chronic conditions most, while leading to a fall-off in consultations for acute conditions. Our study did not specifically investigate this, but the results suggest that for each age group of patients those last consulting the general practitioner for chronic conditions were more in favour of appointment systems than those last consulting for acute conditions, and were more likely to feel that their appointment system worked well.[2]

The relative use of general practitioners by different social groups may also be influenced by an appointment system. As well as favouring those groups who are more likely to consult general practitioners for preventive care and care for chronic conditions it may favour the more articulate patients, those who are more used to coping with bureaucratic procedures, and those who are more familiar with using telephones. Morrell and Kasap found that introducing their appointment system reduced the consultation rate in social class V and increased it for classes I and II.[7] Our study did not investigate this. If, however, appointment systems do facilitate the use of general practitioners by classes I and II while discouraging use among the lower classes this would further increase health inequalities. The Black Report showed that the lower social classes have greater morbidity and higher mortality rates and therefore have a greater need for primary health care,[8] yet, appointment systems *may* act as more of a barrier for these groups.

The introduction of appointment systems has been the major reason for the growth in the number of receptionists. It is no longer relevant to talk about general practice in terms simply of the dyadic doctor-patient relationship, since the first stage of seeking a consultation requires an encounter between the patient and the receptionist. Many general practitioners see the receptionist as a kind of "colourless sounding board" who simply acts as a passive intermediary between patient and doctor, but we maintain that receptionists have varying amounts of informal power—they are able to influence who sees the doctor, when and where. So, with the expansion of appointment systems, the receptionist's function becomes more prominent.

Conclusions

Appointment systems are now an accepted feature of general practice, providing many benefits to both doctors and patients. There is one potential major disadvantage of appointment systems: patients with acute symptoms may not be able to see a general practitioner when they want to. This can, however, be successfully avoided in practices which run appointment systems that are sensitively organised and allow for flexibility in bookings and allow the patient to decide when he or she needs to see the doctor.

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Innovations in London

Great Chapel Street Medical Centre

D J EL KABIR

The Great Chapel Street Medical Centre for the young homeless opened in January 1978. It was designed as an experiment to provide general medical services to the young people who drift about the West End of London, often without fixed abode, and who have difficulty in obtaining acceptance by or are reluctant to go to local general practitioners.

The events that led to its inception date to some years before and reflected a growing concern about the medical and social welfare of this kind of patient. A report from an ad hoc conference pinpointed the needs of such patients to the Department of Health and Social Security. Negotiations were initiated by the Campaign for the Homeless and Rootless (CHAR), the West End Coordinated Voluntary Services (WECVS), with the help of the Kensington, Chelsea and Westminster Area Health Authority. The DHSS agreed to finance the project and to earmark funds for evaluation. Various charities contributed funds. The centre was initially run by a management committee representing the agencies that set it up. Since April 1981, when the DHSS funding stopped, the centre became a branch surgery, with supplementary financial contributions from the district health authority and the management committee became an advisory body.

My work with the centre came about through several fortuitous circumstances. A few years earlier I had resigned my

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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 empathy with the misfit who couldn't 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 WECVS, such as the Soho Project (for help with housing and social problems), Centrepoint (who run an emergency night shelter), and 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, tranquillisers, 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 tranquillisers. 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 noticeably 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 ventilate them. His inadequate personality and his congenital facial palsies compound the unfortunate face which he presents to the world. Recently he started to have blackouts 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 responsibility. 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 these 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 much in the air lately. If 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.

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 your 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 "doppelganger." 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 impossible.

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-timer always seems better at any one. I suppose that each job contributes vicariously to the other ones 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 weeks. 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 foxskin 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 practitioner. 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 only, he would not neglect to fill it with water before he replaced in on his head.

After the Rev William's death a dispute arose about his competence in managing his affairs. This entailed exhumation for the surprising purpose of showing that he was *non 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?" Did he really deflate an extravagantly millinered lady complaining of headache by advising her to decrease the weight of thatch to relieve the load? And was an old farmer "stiff as an old horse" told to wash and remove the weight of the 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." "Table 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 clay pipe out of the window and threatened to throw the smoker as well if he continued to protest.

In his personal hygiene he was obsessionally clean. Each day he wore a clean white tunic, freshly hand-washed by his mistress Gwenllian 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 damp. 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 styles, 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 Chartists 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 fire leaping on Caerlan 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 pageantry 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 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 diatribes 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. Jesus may be an acceptable name in popish Spanish places, but Jesus Christ 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 Penelopen died only a few years ago.) The crowd interfered and the doctor had to be saved by the police—though he strongly denied the accusation.

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 so done as to 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 character, 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 8s 2d.

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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 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 six 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 orals 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, television, 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 money 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 stifling of complaint by "stuffing 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 was 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 such 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 jobs and, provided it is arranged so that they don't have to do 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 scales 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 needs 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 at, 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 the 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

Dr William Price in his suit of scarlet merino wool with green silk lettering. This photograph appears as the frontispiece of his extraordinary *Gwyllilis yn Nayd*, published in 1871: this is Priestan 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 *coelbren y beirdd*, and in the other the mundane egg, or the emblem of immortality.

Gwyllilis yn Nayd seems to finish with a reference to this suit of "tights," which his daughter Penelopen 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 cold egg which you see on my clothing, and his wand 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.