MEDICAL PROBLEMS THAT PRESS.

I.—THE PROBLEMS OF PRIVATE PRACTICE.

By "STEPHEN ANDREW."

To a good many of us average G.P.s it is becoming daily more and more evident that the bottom is dropping out of General Practice. The public has discovered the Specialist, and seems inclined to like him better than the family doctor. The gentlemen of the House of Commons have begun to take an interest in matters of health, and have invented several varieties of the State doctor, to the infinite disgust of the more old-fashioned kind of G.P. Hospitals are catering for an ever-widening circle of working-class folk who in the good old days would have turned up their noses at free doctoring. Midwives—uniformed, certificated, equipped with the very latest thing in antiseptics—run extensive midwifery practices entirely on their own. It cannot be disputed that the palmy days of practice are gone and that it is becoming daily more difficult for the average G.P. to make a living.

A Plea for Action.

Now, it is all very well to grumble; but it is of little use, unless the grumbles lead to something tangible—to some concerted plan for mending matters. G.P.s in the past have been expert grumblers; but as reformers they have not been a success. It has been—and still is—easy enough to get almost any G.P. to agree that "practice is going to the dogs"; but try to get a couple of dozen of them to work along any particular road of reform, and see what happens. (The writer has played that particular game, having been secretary of an anti-cheap-club movement, and knows something of the difficulty of trying to shepherd a team of individualistic-minded G.P.s, nearly every one of whom would bolt on the least excuse.) Yet, that the G.P.s of this country will have to do something for their own preservation—and very soon, too—is obvious to everyone who gives himself the trouble of thinking.

The General Practitioner's Position.

Consider the present position of the G.P. He has spent several years, and a considerable sum of money, in gaining the right to practise—that is, the right to sign death certificates, and to recover fees in the courts. He has spent more years and more money in building up a practice; and, having succeeded, he finds that he is expected to be on duty for twenty-four hours a day, seven days a week, to be ready—and, to all appearances, pleased—to go out at any moment, in any weather, to any sick person who may choose to send for him, and who may not have the faintest intention of paying him any fee whatever. The penalty for refusing to be on duty twenty-four hours a day, seven days a week, is a reputation for slackness and a speedy drop of income. In spite of all this, it is a lamentable fact that numbers of G.P.s are constantly harassed by financial difficulties. They work hard, but fail to make more than a bare living. Others, while making very fair incomes, work so hard that they have very little opportunity of enjoying the incomes.

The Difficulties.

Without doubt the average G.P. has to make up his mind to a life of little comfort, much discomfort, and, only too often, financial worry. These things, however, form only part of his troubles. He growls at them, and perhaps dismisses them with a laugh. What bothers him more, if it bothers him at all—that is, if he thinks about it—is the knowledge that he is very largely futile: that he is undertaking work which he cannot possibly perform properly. He is faced with these two difficulties: (1) He has to make a living for himself and his family; (2) he has to do what he can to relieve the sufferings of sick people, many of whom are very poor.

The two problems combined are so perplexing that many men—particularly those engaged in practice in mean streets—are arriving at the conclusion that the present machinery of general practice is ready for the scrap heap; that an entirely new system must be evolved. They see, only too clearly, that the interests of the G.P. and the interests of the patient are opposed, *that is, when the patient is poor.* The doctor has to choose between giving the patient less than the patient needs, and working at less than a living wage. It is a constant experience with all G.P.s who work in poor districts to meet with patients too poor to pay a doctor, too poor to get necessary medical comforts, too poor to get even sufficient sick-room food. True, there is the parish doctor and there is the local Board of Guardians, who, in theory, meet the needs of these poor people. In practice, however, the parish doctor and the Board of Guardians are found not to meet the difficulty. Then there are hospitals and other medical charities. These do much to relieve poor people who are sick, but they do not do anything like all that they ought; and, in addition, the working of most medical charities is open to a good deal of criticism.

The Need for Reform.

At the present time the general practitioner of this country is working under conditions of great disadvantage. He is badly paid, he is overworked, he is unduly harassed with worries of all sorts. At the same time, thousands of patients are being treated with considerably less attention than they need. And, be it remembered, it is not only the very poor person who has to go without proper medical attention because of his poverty. There are numbers of people who cannot afford to be ill, and who do not come within the reach of the parish doctor or the Guardians; who are not considered fit recipients of medical charity at a hospital or elsewhere.

There is urgent need for reform in the relations between doctors and patients. If that reform is to come, however, the whole subject must be considered

with minute care. It is necessary for the subject to be looked at from every point of view—patient's as well as doctor's. If this be done—well, not only will most of us agree that the bottom is dropping out of the existing system of general practice, but also that the sooner it drops out the better will it be for everybody. For—and herein lies the cause of most present-day medical perplexities—the present system of general practice is built up upon the principle of private enterprise. The G.P. depends for a living upon the chance fees of the sick, rather than upon the regular payments of the healthy.

MEDICINE.

DEATH FROM GALL-STONE COLIC.

GALL-STONES may lead to death directly as the result of the acute colic they may produce, the patient at the same time suffering from a fatty heart as part of the general obesity that is so frequently associated with the development of gall-stones. The intensity of the pain in these cases may be sufficient to cause fatal failure of the fatty heart, as in the following instance:—

A married woman, fifty-three years of age, and now enormously fat, had had eleven children and seven miscarriages. The only previous illnesses of importance that she gave a history of were scarlet fever when she was eleven years of age, and an attack of acute abdominal pain, similar to that from which she was now suffering, but much milder in degree, twenty-five years ago. There may have been minor attacks of pain in the interval between then and now, but they had not been particularly severe. For the last two months the patient had been feeling unwell with symptoms of flatulence and dyspepsia, but she was not seriously ill until seized on March 2 with very violent pain in the upper part of the abdomen, the latter continuing intermittently until she was admitted to the hospital on March 8. During the week preceding her admission she had been sick many times, but her bowels had been opened regularly. She thought that the pains were worst about thirty minutes after food, but it was difficult to make out anything very definite upon examination because she was so exceedingly stout. The skin and sclerotics were of a slightly yellowish tint suggestive of jaundice, though they were not deeply tinged. From her general appearance one gathered that she was in great pain, and on palpation the abdomen was tender, especially above the umbilicus and to the right of it; there was no rigidity of the abdominal wall and it moved fairly well with respiration. The lungs were emphysematous and non-consonating râles and rhonchi were heard over both sides of the chest. The heart was difficult to hear, partly on account of the emphysema of the lungs, partly on account of the sounds produced by the bronchitis, partly on account of the general fatness of the subcutaneous tissue, and partly on account of the feeble action of the heart itself; but no bruit could be heard and there was no œdema of the legs, though the urine contained a trace of albumin.

By March 15 the patient was no longer in pain, but she still suffered from bronchitis and was very short of breath. On March 19 the yellowish colour of the skin became more pronounced and the acute pain in the right upper part of the abdomen recurred with greater intensity and the patient was repeatedly sick. Morphia injections were required on account of the great severity of the colic. About 4 P.M. upon March 21 the general condition of the patient became suddenly worse; the respirations being rapid and shallow, the pulse exceedingly feeble, and the face and extremities cyanosed. Consciousness was retained until a few minutes before death, which occurred at ten minutes past four.

Previous to post-mortem examination the most obvious feature in the case was the acute failure of the heart and there was some question as to whether the pains in the upper part of the abdomen may not have been referred in some way from the heart; at the autopsy, however, a large solitary gall-stone rather bigger than an ordinary corn was found impacted in the common bile-duct close to the ampulla of Vater, where it was beginning to press through the mucous membrane into the duodenum in such a way as to suggest that had the patient survived a few days longer the calculus would have passed into the bowel with complete relief to the abdominal symptoms. The gall-bladder was contracted, small and embedded in adhesions, the result of former local peritonitis, due no doubt to the inflammation associated with the gall-stone. It seems likely that this big stone had begun to pass down the cystic duct about March 2 and that it had reached the common bile-duct about March 8; it then ceased to advance for a few days, without yet being entirely impacted in the common bile-duct; that on March 19 the stone began to pass down the common bile-duct again, jaundice now beginning to deepen once more and the pains recurring with increased intensity; the stone had very nearly succeeded in passing the whole way through when the patient died of acute failure of the heart. The latter weighed 548 grams; but the greater part of this increase in weight was due to fat and not to heart muscle. Indeed, the actual thickness of the myocardium was less than normal, and even that which looked like heart muscle was markedly streaked with yellow lines of bile-stained fat, whilst over the whole surface of the heart there was such an excess of adipose tissue that it was not at all surprising that heart failure came on acutely at the end. Nevertheless up till the time of the acute biliary colic the heart was well able to do such work as was required of it, and the final factor in producing the fatal cardiac failure was a recrudescence of severe biliary colic, which, therefore, was the immediate cause of death.