Those were the days...

The following reflection was triggered by a news release by Paul McCormack in the Christchurch Press on 23 January 2004. In this he says, 'It is entirely possible that the general-practice service as we know it, the corner stone of our New Zealand health system, may disappear within a decade'. *The paper is written by the widow of a GP who died in his mid-80s a few years ago.*

On reading Dr McCormack's article in *The Press* today about the crisis in general practice with all its problems and yet with all its interests and rewards I was set to thinking about practice in New Zealand immediately after the war. Life has changed in so many ways and yet the basis of work for a family GP has remained the same – as Dr McCormack says 'GPs have a great job – we get paid to talk to our friends'. Well, perhaps one slight difference – we often got 'paid' with a bag of potatoes or kumara, a jar of cream, or whitebait in season – that's real friendship (and it included 'we'll pay you next time doctor').

How did we get involved in general practice? I say 'we' because although G was the doctor, I, the wife, had to cope with the 'mechanics' – phone calls, patients at the door, and standing in when the one nurse-receptionist (no practice nurses in those days) was sick or away, not to mention the surgery washing and cleaning. During the war G was working as an orthopaedic registrar at Wellington Hospital, but like most men of his generation, felt he should be overseas helping the wounded and sick. However, he couldn't be released until he found a replacement. Eventually a doctor returned to New Zealand after a horrifying time as a prisoner of war. He'd been very ill and was repatriated. So he took over G's job and G went to Egypt and Italy where he remained on duty doing orthopaedics until about a year after the war ended, as there was only a gradual shutdown of the army hospitals. Naturally, when G came back he couldn't expect to get his old job back from his replacement who was senior to him, so the hunt began for work. He managed to get a position with the Waikato Hospital Board, which we assumed was at Hamilton Hospital. It turned out to be Rotorua Hospital doing more or less a senior House Surgeon's work, including minor surgery, obstetrics and anaesthesia. He had done locums before qualifying and during the early war years as GPs were desperately in need of relief; many being in sole charge of large practice areas as the number of doctors going overseas increased. Medical students in their final years were called upon to help out – a huge learning curve. However, it stood G in good stead to make the move to general practice after working for about a year in the hospital. He was encouraged to do this by the few GPs in town who were all overworked and who were most helpful. So he set up on his own, putting a brass plate on the front gate, renting a couple of rooms in town as a surgery and waiting for patients to turn up, which thankfully they did and soon it was a busy practice.

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Somehow we had managed to buy a little old car – a necessity in general practice. After travelling miles over unsealed pumice roads to calls in the country it parted with its exhaust system one night, manoeuvring through a field. I could hear it coming from afar. Eventually, though patched up and coaxed into action, it decided enough was enough and stopped dead in the driveway. It was extremely difficult to buy a new car as imports had just started again after the war. Only those in 'essential jobs' could get them, so when two beautiful black English Vauxhalls arrived one went to the local taxi driver and one to us. A great relief to have a reliable vehicle and reassuring for me when G disappeared into the night after surgery to drive 20 to 30 miles to a patient. Very few of the country people had cars so couldn't bring sick people in at night. There were no such things as cell phones so communication with the doctor in his car was impossible. The manual telephone system was a help with an operator who answered when you rang in (a lot of people were on party lines and could listen in – a doubtful benefit sometimes). The operators were a wonderfully helpful lot, especially at night. I would give them a list of

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phone numbers where G had calls and they would ring around until he was located and then relay a message, either another call in the area or more likely to tell him he was wanted urgently at the Maternity Annexe.

The government had instituted a Social Security Benefit for patients who were refunded 7/6d out of the 10/– fee so they only had to pay 2/6d in cash. Prescriptions were not charged for and bloods and urines were tested free at the hospital. There was also a mileage fee, rather inadequately paid by the government for 'distant visits'. It was usually not until several '2/6's were owing that an account was sent. All patient notes were written on 8x4 cards and filed in alphabetical order. It was easy to mislay one if someone didn't know their alphabet. Then there'd be a frantic hunt looking through all the 'S's say for someone called Smyth not Smith. Results and reports were kept in separate cardboard folders in another cabinet. Eventually we had one room full of files and folders as no-one's notes were ever thrown away. Patients could go to live elsewhere, come back 20 years later and their notes were still there.

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G really enjoyed obstetrics, despite the broken nights and interrupted appointments, seeing the children grow up and getting to know their families. During those early days more Maori women were coming into hospital to have their babies instead of having them at home when the doctor would have to leave the surgery to check that all was well. Everyone waited! The Superintendent had managed to convince Maoris in general that hospital was a place in which to get better instead of assuming they were coming in to die, as they had previously believed. G had many Maori friends and was occasionally called upon to speak at celebrations such as weddings and birthday parties. It was a great regret that he couldn't speak fluent Maori – he did have some lessons but never had the time to really master the language, so spoke in English, which they all understood, but most of the speeches would be in Maori for special occasions and someone would translate.

We had one little boy when we arrived in Rotorua and subsequently had three more children, a girl and two boys who somehow brought themselves up to be wonderful young people. There were some difficulties in living a so-called 'normal' family life as in the early days G was on call or working 24 hours a day seven days a week as were the other GPs. If we wanted an outing or a weekend off we had to ask one of them to cover and we would do the same. If a patient was in labour the picnic would be postponed and many a time I would get food and children ready to go to the beach 'If Daddy doesn't have a baby'. When we did get away it was always a great joy to us all to spend a day away from the telephone even though on arriving home there was a list of calls waiting to be done.

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After more than 10 years in practice G was in need of a break as he was doing anaesthetics as well as obstetrics and general practice and was often up two or three times at night and still off to work early in the morning. We were fortunate to find an excellent locum who came for several weeks and then stayed on as G's partner. From then on we were able to have regular time off and G found it easier to take part in many local activities and develop interests outside medicine. But it was the practice that was the major part of his life, and until he started delivering the grandchildren of his first maternity patients he continued with obstetrics, although there were not so many deliveries as the patients had grown older with him!

Things changed with the next generation and now, nearly sixty years later, one fears for the future of general practice – let's hope that fear is not realised.

'The physician-patient relationship is at least as complex and ambivalent as any other intimate human relationship. It takes time and energy and delicacy to cultivate. Like marriage, it is not a state to be entered lightly or unadvisedly. So I always begin by believing the patient and taking the complaints at face value, even if, later, I have to confront the incongruities. I am not a surveyor, a poll-taker, an interrogator, or a prosecuting attorney; I do not merely collect data towards which I am affectively neutral or a dispassionate observer. Often I must disclose myself in the process of coming to understand a patient. There is no way to keep the meeting completely safe for me if it is not equally safe for the patient. Both must take the risks of getting to know the other when medicine is practiced in the most effective way.'

– Stephens GG. Reflections on a post-Flexnerian physician. In: White K, editor. The task of medicine. California: The Henry J Kaiser Family Foundation, 1988, p180.