

## “All changed, changed utterly”: recollections of 40 years in general practice

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It was towards the end of 1963 — my final year of medical school at the University of Melbourne — when I read about the new contraceptive method in the *Medical Journal of Australia*. On our last day, after the Professor of Obstetrics and Gynaecology bade us farewell, I ran after him and asked:

“Professor Townsend, what do you think about the Pill?”

“It’s good stuff,” he replied, with a smile and a wink.

And so I began my career just as the sexual revolution was poised to change society forever.

One of my first patients was a migrant from Eastern Europe, who was raising two children as a single mother in the days before the safety net of generous social security benefits. She performed her own abortion with a knitting needle when I could not find a doctor to do it for her. But, as the years went by, struggling women and blushing teenagers came to me instead for “Anovlar”. Gradually, the unwanted pregnancy became less common, and so, thankfully, did the do-it-yourself abortion.

In 1963 there were few female GPs. Indeed, some patients never came into contact with a female doctor. Once a 3-year-old child of one of my patients, staring with a puzzled look as I examined his mother, asked in Hungarian: “Mummy, is this lady a gentleman?”

Our family practice was situated in Elwood, a suburb that was then a bit “rough around the edges”. The practice started in a flat, with the living room serving as the waiting area. This arrangement did not worry our fellow compatriots and the other colourful immigrants of various religious and ethnic backgrounds who streamed through the doors. And Australian women came from all over Melbourne to see a female doctor for their “women’s problems”. Gifts of paintings, flowers, handcrafts, boxes of chocolates, and silver plates engraved with messages of gratitude all adorned our home. Every year I still receive a Christmas present from an Italian family I stopped treating long ago.

We worked 6 days a week and attended emergency calls each night. There was no time to stop and smell the roses; I noted the changing seasons by the reappearance of patients with chronic peptic ulcers in the spring and autumn. What a difference the first histamine H<sub>2</sub>-receptor antagonist made! Not to mention proton-pump inhibitors. I often think about the patients who suffered penetrated, perforated or bleeding ulcers before the advent of these drugs. I can recall more recent cases too, but most of these were iatrogenic, as a result of taking non-steroidal anti-inflammatory drugs (NSAIDs). When I started practice, phenylbutazone was the only anti-inflammatory drug available, and I’ll never forget the life-threatening Stevens–Johnson syndrome that it caused in one of my patients. It was a relief when indomethacin and the other NSAIDs, and later still the COX-2 inhibitors, came along as alternatives.

The way we viewed and treated cardiovascular disease changed over the years. In the early days our waiting room was awash with

ashtrays. We doctors sometimes even smoked with our patients! We also knew all about the links between cholesterol and heart disease, but didn’t take it too seriously, as there were no effective cholesterol-lowering drugs.

I remember attending patients with suspected acute coronary occlusions in the surgery, in their homes, on the street, and on garage floors. They were common occurrences, and neither ambulances nor hospitals had coronary care facilities or units. Still, I clearly remember saving the lives of two patients by rushing them to hospital and arriving just minutes before they had a cardiac arrest.

The treatment for hypertension was straightforward and simple compared with the choices we have now. We used mainly Aldomet and chlorothiazide; our aim was a blood pressure of 140/90 mmHg, although 150–170/90–95 mmHg didn’t alarm us. In the elderly, high systolic pressure was generally not treated if the diastolic pressure was normal. In those days, near enough was good enough.

The new and effective cardiovascular drugs came slowly, and a few decades later we began to notice that our patients were living longer and not succumbing to early heart attacks and strokes.

I often think with great sadness of the friends and patients who died at that time, but might have been saved with better medications or bypass surgery.

I still remember the suffering of patients with severe chronic asthma that I couldn’t adequately treat. All we had was ephedrine and phenobarbitone, combined with aminophylline or theophylline. We used adrenaline in emergencies, and also had prednisolone, but did not know how to use it safely. No wonder we embraced the first salbutamol and steroid inhalation devices, and later the individual asthma management plans, so enthusiastically!

In the late 1960s, I saw a one-year-old baby with a minor complaint. To my horror, the next patient was an 8-year-old with a high temperature, cough and Koplik spots. I feared for the baby, who would surely catch measles from the 8-year-old. I knew the incubation period for measles was 2 weeks, but remembered reading about a new vaccine that gave protection within a week. I urged my pharmacist to try to obtain the vaccine for me, as it was not yet readily available. Luckily, it arrived and was given to the baby the same night. He never developed measles!

I probably overprescribed antibiotics for many years, especially penicillin, but I am proud that no child in my practice ended up with damaged eardrums, rheumatic fever, nephritis or chronic chest infection, and I can’t remember many tonsillectomies either. On the other hand, a lot of patients developed thrush.

I remember using antiviral drugs for the first time — to treat herpes zoster and a severe case of genital herpes — and dreading the side effects that, in fact, never came.

We used barbiturates freely for anxiety, nervousness and sleeplessness. The 30 mg amylobarbitone (Amytal) was even more popular than Valium is today. The 200 mg dose Sodium Amytal was a good hypnotic — and a common cause of successful suicide! One of my patients took all 25 capsules, never to wake again.

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By contrast, not so long ago, one of my young patients reported downing 25 Mogadon tablets at once.

“What happened?” I asked.

“I woke up 2 days later,” she replied.

“How did you feel?”

“Very hungry!”

No wonder, given their obvious safety (although, of course, it's no excuse), we overprescribed the benzodiazepines. It is still an ongoing problem.

The introduction of ultrasound, computed tomography scanning and endoscopy, and the new, less invasive surgical procedures, had a revolutionary effect. I remember the first of my patients who braved a laparoscopic cholecystectomy when it was still a very new procedure. Both of us were pleased with the outcome.

Substance misuse, especially drug addiction, was always a problem in the Elwood area, and sadly remains so. The relationship between user and doctor was mutually unsatisfactory. The addict failed me by lying, cheating and stealing. They came not for help, but for drugs. I, in turn, failed them, because I refused to supply the drugs they craved.

Even little things like disposable syringes, office pregnancy tests and one-drop blood sugar testers represented a great leap forward. Later still came the mobile phone and the computer, and no more arriving home only to be immediately called out again, and no more misplaced reports.

Medicare deserves a whole chapter. For my practice, it meant I could order pathology or radiology services for pensioners, who previously had to attend public hospitals for these services. Sometimes, very poor patients were given free treatment, and this dilemma was also solved by bulk-billing.

As the years flew by we had to learn about new diseases and their social impact, such as chronic fatigue syndrome, and new infectious diseases — AIDS, hepatitis B and C and, most recently, SARS. And diseases that were once less prevalent, such as type 2 diabetes mellitus and breast and prostate cancers, now became more common. As people ate more and exercised less, obesity reached epidemic proportions. Sleeping with multiple partners increased the prevalence of genital herpes.

When I first started, choosing specialists was easy. Today, it is a matter of matching the right specialist to the right condition, as specialists themselves are now increasingly specialised. You have to know which orthopaedic surgeon is experienced at hip replacements, and which gynaecologist treats stress incontinence.

But along with the new advances came the demise of the “old-style” doctor, devoted to treating several generations of the same family — the doctor who does home calls and has patients whom he or she has seen for 40 years or more. Now, fewer and fewer doctors are willing to do house calls, while the public expects service from early morning to late at night and during weekends, something no single doctor can provide. Doctors, whose only duty was to look after their patients, now spend a lot of time and money protecting themselves from potential litigation.

With these pressures, I too eventually joined a mega-clinic with efficient, up-to-date, accredited services. The patient care is excellent, but also less personal.

And while we look to evidence-based medicine, the public spends more and more money on poorly regulated and sometimes harmful “natural” therapies.

So, how would a wish-list of a doctor nearing the end of her working life read? What do I want that we still haven't got? Try this:

- a simple, non-invasive test for detecting colon carcinoma;
- clearer guidelines about when and how to investigate patients with high erythrocyte sedimentation rates and high C-reactive protein levels;
- still safer NSAIDs;
- guidance on when to stop postponing death and begin palliative care;
- a clever device for testing blood sugar that would administer insulin automatically;
- more places for taking long walks safely in our suburbs and towns;
- a society in which families take more responsibility for their elderly relatives;
- baby-friendly workplaces; and
- less violence in films, videos, computer games and, of course, in life itself.

Yes, general practice has “all changed, changed utterly”\*.

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\*Easter 1916 — William Butler Yeats