

Reminiscences and Reflections

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Lloyd McCarthy was born in Madelia, MN. After serving in the U.S. Navy in WWII, he attended Carleton College in Northfield, MN, where he received his Bachelor of Arts degree. Following graduation from medical school, he served his internship and general practice residency at Evanston Hospital, Evanston IL, an affiliate of Northwestern University. He was in general practice for thirty-five years in Barrington, IL, a commuter community northwest of Chicago whose population more than doubled from 4,500 during Dr. McCarthy's career. While in practice, he served a term as president of the medical staff of Sherman Hospital, Elgin, IL. Since retirement in 1991, he and his wife, Mary, have been active with local conservation organizations, bird watching, traveling, and photography.

In 1956, in a suburban setting, I began a solo general practice, which was to last 35 years. When I started practice, I became that often referred to “LMD” (local medical doctor) in our students’ medical histories and physical exams. General practice allowed me to practice “one-stop” medicine for the entire range of medical maladies. There was great satisfaction in making office diagnoses, both mundane and esoteric, and initiating or completing treatment in one setting.

General practice gave me the chance to know the whole patient and his family, which in many instances included four generations. We shared happy moments and sad moments. The practice was challenging, satisfying, and enjoyable.

Patients did not have to make appointments. All who came were seen and given as much time as needed. A concerned patient was not required to wait anxiously for an appointment sometime in the future. Sometimes office waiting time was prolonged, but there were few complaints. Those with acute illnesses or significant injuries were seen without waiting. Those needing only a routine immunization or allergy shot were seen between patients. When possible, phone calls were returned between patients. No one enjoys waiting all day for a return phone call.

At the University of Rochester we were expected to dress like doctors and throughout my practice the uniform of the day was shirt and tie.

House calls were frequent in the early years and were often somewhat social as well as medical, except those of a tragic nature. House call sites varied from a jail cell to a convent, from a migrant worker's dirt floor house to a millionaire's mansion.

Traumatic death scenes included those by lightning, fire, drowning, gunshot, auto

and plane accidents, and train-pedestrian encounters. Fatal acute MI's were equally as tragic.

The black bag was always with me and its contents included an assortment of diagnostic equipment and medications. Among the injectables in the early years were adrenaline, morphine, mercurhydrin or thiomerin, cedilanid, quinidine, aminophylline, decadron, compazine and sparine. Episiotomy scissors and Kelly clamps were included and were needed, once most urgently as a teenage primipara was delivered on a Sunday morning on her parents' living room couch, much to their astonishment.

Bedside conversions of arrhythmias were occasionally performed. Twice, at his home, I was able to convert the cardiac arrhythmia of a longtime patient. On the third occasion he drove twenty miles to my office where I obtained an EKG record of the arrhythmia. If any of you internists or cardiologists think that you can't convert ventricular tachycardia with cedilanid and quinidine, you are wrong. But don't try it.

For the first six years an office visit meant finding a parking space, feeding the parking meter, and then climbing steep stairs to my second floor office. The frequency of house calls diminished when I purchased a freestanding medical office building from a physician who was going into corporate medicine.

Until the advent of paramedics, emergencies were announced by the sounding of the fire whistle and responded to by the police and volunteer firemen. For several years I was essentially the only available physician in town and, invariably, when I heard the fire whistle, I could count on hearing my phone ring within a few minutes. With paramedics available I was able to block out the sound of the fire whistle. On the other hand, many patients who could have been treated at home or in the office were transported to the hospital at much greater cost, not just to the patient but also to any third party payers.

Because of the Salk vaccine I saw no polio patients after my internship, but before the widespread use of the measles-mumps-rubella vaccine childhood diseases were common and resulted in my contracting mumps. Other infectious diseases seen only occasionally included tuberculosis, sexually transmitted diseases and typhoid fever, including a "Typhoid Mary"- an asymptomatic carrier of the typhoid bacillus in her gallbladder. The diagnosis of malaria was usually easy: the patients (African nationals) knew their diagnosis, told me, and left with a prescription for quinine, all for only the cost of an office visit. Not until my last year in practice did I have an HIV-positive patient.

With early diagnosis and treatment, scarlet fever and its sequelae virtually disappeared. My few meningococcal meningitis cases were diagnosed early and successfully treated. Development of newer antibiotics greatly helped in the treatment of respiratory and urinary tract infections.

Night calls were frequent until the Emergency Room had full-time physician coverage. Then families either hesitated to call me or felt that an ER visit was more

convenient and more likely to be covered by insurance, thereby contributing to an escalation of health care costs.

Another change in my practice came when I stopped doing obstetrics. The number of infants whom I saw and followed through their teens dropped rather quickly. The age of my patient base increased and with it came more of the problems of the aging.

My surgery was limited to minor procedures, but I did assist on major procedures. Patients and their families expected this. It seemed to offer them some feeling of security and confidence to have their family physician present at the time of surgery and assisting in the post-op treatment to assure continuity of care. The development and increasing use of minimally invasive procedures made an assistant surgeon superfluous. In addition, insurance policies eliminated payment for assistant surgeons. Our 450-bed community hospital had the full range of medical specialists with whom I had good rapport.

Medicare, HMOs and managed care all had some impact on my practice and the physician-patient relationship, although I was never in a position where it was necessary to become a part of an HMO or managed care program. Some patients became locked into their employer's HMO, but a few still consulted me when access to the HMO physician was difficult.

Hospital inpatients decreased dramatically with the development of minimally invasive and non-invasive procedures, which allowed for short-term stays or outpatient procedures.

With the arrival of cardiologists and, later, cardiac surgeons, total care passed to them. Our community hospital is now one of the top three cardiac surgical facilities in the metropolitan region in terms of numbers and favorable outcomes.

My retirement came before many practice procedures became mandatory: OSHA, hazardous waste disposal, procedure manuals, job descriptions, documented office staff meetings, coding of diagnoses and procedures, computer-generated billing, office lab inspection and licensing, and now HIPAA with its onerous privacy act provisions. As Dr. John Romano perhaps would have said, “fiat and ukase by intrusive do-gooders.” For a general practitioner with two employees, this could be overwhelming.

I have now come to know the meaning of “the waiting room” as I wait for my turn to see the internist or urologist. As I look around the room, I see mostly patients whose best days are behind them. Then I recall my office waiting room, filled with people of all ages, from infancy onwards, engaged in lively conversation with their friends and neighbors.

Developments in the field of medicine have grown by leaps and bounds, but now each body part belongs to a different specialist. Rare is the physician who can, or should,

give total care. I have the impression that the interaction between physician and patient is less caring, without any strong bonding or a lasting relationship and that the physician-patient relationship now is often adversarial.

I left practice with the feeling that I had developed a strong physician-patient relationship based on caring and compassion, engendering a feeling of trust. Credit for this began with the superb basic instruction and training in our formative years at the University of Rochester.

I still live in the community where I practiced and now I think of my former patients as friends when I meet them socially or on the street or in the supermarket.

Since retirement what I miss most is the office interaction with patients, not just medically, but our conversations on topics both personal and universal. In addition, I cannot forget the zucchini and tomatoes from their over-fertile gardens or the holiday season jams, jellies and still aging spirits.

There are many memories typical of my practice, one of which I will share with you. Children often asked me to examine their dolls or teddy bears. On one occasion while engaged in such an exam, the child suddenly said, "That's enough. She isn't even sick."

And now I say, "That's enough."