a patient—whether in the form of clinical skills, access to facilities, or emotional support—in both good and bad times is a human not a professionally acquired one. But every situation is unique. In today's medical environment, with its proliferation of guidelines and protocols and the emphasis on efficiency, there is little to help the family doctor in this situation apart from personal experience and inclination.

Dealing with such an awful condition as Antony's, raises all sorts of questions. I have two children of my own and can only imagine what Antony's illness and death have meant to his family. At a discussion early in his illness I was asked what I felt my role was to be, given the input and expertise of Great Ormond Street Hospital, which took over Antony's care. I replied that I was still the family doctor and remained a port, if not the first port, of call. Unfortunately, as is its wont, Great Ormond Street Hospital took over completely, and only in the final stages was any communication from the hospital forthcoming. (In this respect matters are improving, but we are still a long way from a satisfactory team approach to serious and terminal childhood illnesses.) I also had and still have an anxiety over the degree to which anyone, professional or not,

can or should intrude into the family space in situations such as this. The obvious answer might seem to be a process of communication, but that seems to have failed, at least initially. By chance, I was visiting at the moment of Antony's death, and the sense of gross invasion at such a private time still haunts me.

The suggestion that I had misinterpreted the family's needs—which, perhaps, were never signalled—and that I did not do something which might have made a difference and which on other occasions I have done has led me to re-examine the special needs of a group of patients who, as Antony's mother states, will only ever be a very small portion of a general practitioner's work. The complexity and uniqueness of every doctor-patient relationship is a concept that, as a general practitioner trainer and course organiser, I try to emphasise to all general practitioner registrars, but one that has been crucially underlined by my personal experience. That Antony's parents have been able to be open and frank with me about their feelings, and continue to consult me as their general practitioner as they face the future, reinforces what has to be a dynamic relationship, growing and developing with the vicissitudes of shared experience.

Appendix

Neuroblastoma is diagnosed in about 100 children in the United Kingdom each year. Most of these are less than 4 years old. Neuroblastoma may arise at any site where sympathetic neural tissue is found, but the most common site is the abdomen. The tumour may present with a variety of symptoms, although most children initially present with rather vague symptoms that may be mistaken for a viral illness. Some children present with abdominal pain or a limp because of bony involvement.

Treatment of neuroblastoma depends on the site of the tumour, the stage or spread of the disease, and the age of the child. Most children with localised tumours (stages 1 and 2) can be cured, and infants under 1 year old tend to have a better outlook. However, in 65% of

cases the disease is widespread and highly aggressive (stage 4), and the prognosis for these children is poor.

The Neuroblastoma Society has three primary roles:

- To find a cure for neuroblastoma through funding clinical and scientific research
- To raise awareness of neuroblastoma with the public and with the medical profession
- To give spiritual and practical support to those with neuroblastoma, and their families.

An information booklet about neuroblastoma is available from the society. For further details, contact Dr Barry Pizer, Alder Hey Children's Hospital, Eaton Road, Liverpool L12 2AP (tel: 0151 252 5294 fax: 0151 252 5676).

A memorable patient

The accordionist

"Cedric" was a house call in Kibblesworth. I knew him slightly from a couple of previous visits to his equally ancient wife, now sadly passed on. I didn't want to go to Kibblesworth. It's a small village stranded on the other side of the practice, and in the opposite direction to a cosy cup of lunchtime tea at home. Cedric's little bungalow was clearly missing the attention it used to have from his wife. He had had some sort of episode on the way to the post office where "he wasn't himself," not sure of where he was, etc, but he seemed to have more or less recovered.

While musing on the diagnostic possibilities I saw a music stand and a small bass guitar amp in the corner. My curiosity was aroused; it was hard to visualise 86 year old Cedric as a rocker (other than in a parkinsonian way), so I asked about his music. His eyes lit up, and from under a cloth he produced a magnificent black and silver accordion. He invited me to play it, which I did, badly. Despite his arthritic fingers he played it himself, a tune that he had written, a lovely lyrical tune. Then he showed me a trunk full of accordion music.

"That's worth a pretty penny," he said proudly, pointing to dog eared music costing three and sixpence a sheet. Then he turned to his photographs of his army band playing days after the war. His eyes misted up and he wasn't really with me. But I wasn't in the bungalow either. I, too, was in smoky postwar dance halls listening to the band.

"We were the best band around," he said. He should have turned professional, but he went down the pit instead. Perhaps that was what had made him so hardy. He continued to reminisce.

"Ah, but once they just started vamping on the bass, the accordion's days were numbered," he finished up sadly, as he carefully replaced the cloth. There was nothing more to say. I left for a late lunch.

And the diagnosis? I never did make one, but at least now I had visited a person, not a patient, and it made my day.

Paul Vincent, *general practitioner, Birtley, County Durham*