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The family doctor's responsibility to the individual

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" The year 1947 saw the worst winter for 100 years. On the day of the blizzard which ushered it in, I rang up the home of one of my patients who was recovering from pneumonia hoping to escape the visit but to my dismay I heard he was much worse and his supply of penicillin which his daughter, a medical student, was administering had come to an end. I therefore set out on foot for the four miles there and back. The journey, partly on the railway lines, and visit took me more than four hours but my heart muscle, even at 62, must have been in reasonable trim as, after a whisky and soda, I was able to eat a hearty lunch."

THAT extract from *Will Pickles of Wensleydale* (1970) puts in a nutshell his own responsibility to the individual. He began to practise medicine before the first world war, in a society with very different values from those of today, and much has changed in family doctoring during the last 50 years.

This change is well illustrated by the contrast between the buildings. In the main street, whether it be in the town or village, the old doctor's house stands neglected, unpainted, converted into flats or council offices. Next door, there is a fine, new, clinical building with painted wood and metal windows—the communal surgery. The old doctor's house was his home, a visit to him was a personal affair, and a patient would be unlikely to see anyone but the doctor himself. Over the years they would have a relationship which would naturally include a feeling of responsibility by the doctor for his patient, and this would be both expected and accepted.

The scope of medicine was limited both in diagnosis and in treatment, often the doctors knew little more than to observe the course of an inevitable disease, a very different situation from that which we enjoy today in the communal surgery with up to date methods of diagnosis and extremely effective treatment for many diseases which in the old days were fatal. This has fundamentally altered the relationship between patient and doctor, because any well trained and conscientious doctor can make the diagnosis without difficulty, and give the appropriate treatment. There does not any longer seem to be a close personal relationship, and the patient is less likely to expect or the doctor to assume the old responsibility. The patient knows much more about medicine in general, sometimes too much for his peace of mind; the old sense of mystery has gone and he is more likely to be critical and to expect a larger say in his own management. So we should pause and consider to what type of family practice this will lead us in the future, and how we can guide our successors.

Some examples

Take three common situations which occur in a day's work in general practice. A patient is taken suddenly ill or has an accident, and has to be admitted to hospital. Another patient comes with an apparently trivial complaint, yet examination points to serious or even fatal disease. Thirdly, there is a sudden tragedy in a family, a sudden death, a prison sentence, an illegitimate child, or the loss of a job.

In all these situations the family doctor has an initial basic responsibility, the absolute minimum which his contract with the National Health Service obliges, namely

to attend on the patient and give adequate treatment—he can then shut up shop and go to supper. Although this may be the legal minimum, few doctors would be satisfied with this. In the first case of the patient suddenly admitted to hospital, there must be talk with the relatives, many questions have to be answered—Will he get better? How long will he be in? Will he be able to go back to his job? When can I visit him?

In the case of serious disease discovered almost by chance, the doctor has to decide on management in the light of the personality of his patient. How much should he say, and to whom? How much should he tell the patient, or his wife or children? Referral to hospital is bound to cause suspicion, so how frank should we be in telling the patient of our own doubt or certainty?

Finally, when sudden tragedy strikes, how can we best offer support and comfort to the family during the first shock? The degree to which the doctor responds to the challenge of these situations shows how seriously he takes his *responsibility to the individual.* It will depend on his temperament, his conscience, his training, and even such everyday factors as how much time he can spare. It can vary from the bare legal minimum to such a total involvement that it may even become harmful to the doctor or the patient. We must know where to stop.

Until 1954, when Stephen Taylor wrote *Good General Practice*, little had been written about this aspect. Taylor had spent two years visiting practices up and down the country, practices which were known simply as good, because the patients appeared satisfied and on good terms with their doctor who, in turn, was happy in his work and giving a good service. Taylor wanted to find out what made a particular practice tick. In the end there was only one common characteristic of these practices and the doctors who ran them—a sense of devotion to, and *responsibility* for their patients.

There was no geographical connection between these practices. They were found in every social and economic sphere from the isolation of the country to the depths of the slums. One of his most moving reports was about a practice in the poorest area of the London docks—in soil where a perfect flower of general practice seemed unlikely to flourish, was a man not only adored and trusted by his patients, and a rough lot they were, but whose clinical performance was a surprise and delight. Dr Taylor reported faithfully on all that he observed in his visits to the practices, which usually lasted several days and involved interviewing not only patients and doctors but ancillaries, and local gossip points such as public houses and cafés. He was told of one doctor who carried his responsibility to the point that he even left his telephone number when he visited the local brothel!

I believe that we all have this sense of responsibility to a greater or lesser degree and that it can be developed or stifled according to the example of senior partners with established standards and ways of life. I believe that it is quietly present even behind the publicity of wrangles about pay and conditions in the National Health Service. It was certainly one of the first principles that—as medical students we learnt from our seniors—both by precept and example. I believe that this continues, but it was not anything that we thought much about, and it is only comparatively recently that the emotional bond between doctor and patient has been explored. The growing literature has helped us all to see our motives more clearly as well as other factors which regulate our responsibility to our patients—this is the subject of this essay.

Involvement with the patient

Why does a patient go to the doctor? The general practitioner in Britain has often been called the ' doctor of first contact ', but what is it that makes the first contact? It is always in some way a cry for help. It may be a straightforward physical occurrence; a cut, an accident, the onset of influenza; or it may be some deep dissatisfaction and

inability to face life which becomes intolerable; or it may be a mixture of both. It may be a breakdown in the functions of the body due to stress or ageing, but whatever it is, the patient is at the point where he or she feels he cannot deal with it himself and wants help.

The doctor has two attitudes to his patient which directly conflict: he must retain that first impact as a student to his patient, which is subjective and he must be objective and clinical. In other words he must be sympathetic as a fellow human being and at the same time efficient as a doctor.

These two attitudes change in their balance during his professional career, because as a green medical student he has no skill, but he is likely to have much sympathy; while at the end, he will have a great store of clinical experience, but his store of compassion sometimes is reduced. This conflict is felt most keenly in the clinical years in the medical school. We all remember becoming emotionally involved with our first patients, especially the tragic ones—the maimed child, the young woman dying of cancer, the middle-aged man with a carcinoma of his rectum and a permanent colostomy—these have marked us for life, but their lesson should be for the benefit of our future patients.

With experience, familiarity may breed contempt, or perhaps a hardened attitude. There may well be a compensating reaction in a sensitive young man or woman so that the newly-qualified doctor will not allow himself to become involved and may be hard and apparently callous. I remember a stage as a young house physician when I was torn between the pleasure of having a weekend off, and the knowledge that I must leave one of my young patients with an infective meningitis to have her daily lumbar puncture done by another doctor on the house. These were the days before antibiotics and my chief had impressed on me that I must on no account aspirate the purulent fluid from the spinal cord for fear of blocking the foramen of Majendie, but I must allow the fluid to run out under its own pressure. The girl died—24 hours after my locum had aspirated the cerebrospinal fluid, and I still remember the guilt with which my new responsibility loaded me. The young doctor can easily revolt unconsciusly against this new sense of responsibility, and say " Am I my brother's keeper? "

This conflict renews itself when a young man goes into practice, because he comes into closer contact with his patients. I remember two pieces of advice given me by hospital consultants. The first was " Never make friends of your patients or patients of your friends ". I soon found that if I followed this particular piece of advice in a country practice, I should finish either with no friends or no patients; but underlying this piece of advice was sound commonsense, and what was meant was " Do not become too emotionally involved with your patients ". The other consultant put it differently, " Never worry about a patient in your bath, my boy ".

In my early days of practice, a young woman had a baby and developed a breast abscess which, in the primitive conditions of those days, I opened, drained, and put in a tube. It tracked back into the breast and needed further incision and another tube, and eventually I had to get a surgeon down from London. We gave her a general anaesthetic in her bedroom, engaged two trained nurses, and she had an extensive operation which, finally, was successful. When she was better, I admitted to her that I had worried about her to the extent of disobeying this excellent bit of advice. I married soon afterwards and her wedding present to me was the most enormous sponge that I have ever seen in my life.

There is an emotional reaction between the patient and his doctor which varies with each patient and can often cast light on the presenting problem. This has been dealt with fully and sympathetically by Browne and Freeling (1967) in their book *The Doctor–Patient Relationship*. They call it " the sixth sense," and quote as examples the feelings evoked by the patient—anger, admiration, depression, and sexuality. Finally, there is the doctor's professional anxiety, " patients have always known that to involve the doctor they will have to arouse his professional anxiety "; this is another expression of his

responsibility, but it is the other feelings which can give the doctor a clue (if he recognizes them) towards diagnosis.

The recognition of serious disease

Does involvement with the patient help or hinder a diagnosis? The overriding responsibility in general practice is the recognition of early symptoms of serious disease and nothing must be allowed to interfere with this. Whatever it is that brings the patient to the doctor—the presenting symptom—he must always have these questions in the front of his mind—Is this significant? Is it all? Am I quite sure? The patient has put his life in the doctor's hands at this stage just as much as in submitting to a surgical operation.

As a dresser in a gynaecological ward, I remember two women lying side by side. One was in for an examination under an anaesthetic for irregular bleeding, the other had an inoperable carcinoma of the cervix. Both had gone to see their general practitioner at some point, but how had the inoperable case been missed? If she had seen her doctor in the early stages, then he had failed to exclude the early signs of a malignant growth; if she had gone late, there was failure of communication between herself and her doctor. Perhaps it was the patient's fault for not going sooner, but when she first felt that something was not right, what was it that kept her from seeing him? Was it some previous experience of being told off for worrying him with trivialities?—or of getting that impression?—fear of lack of sympathy?—fear of being told the truth?

It is a counsel of perfection to say that a doctor should have such a relationship with all his patients that they will always consult him if in doubt. It is, however, an aim which we must try to foster; it is so easy to brush off a patient with a trivial ailment so that when something serious presents they come too late.

Patient and doctor may well have different ideas as to the extent of this responsibility. Well-intentioned interest on the part of the doctor may be looked upon as unwarranted interference by the patient. An aggressive patient can accuse him of being nosy; this situation may arise when the possibility of a deep-seated illness is suspected in a patient who presents with an apparently straightforward minor ailment. For instance, a man of 50 has a chronic ulcer on a toe: is there diabetes, is it early gangrene, is there atherosclerosis of the arteries of the leg? It is essential to find out, which means taking his blood pressure, a sample of his urine, possibly his blood, and further investigations. The patient's reaction may be:

" It's just me bloody toe doctor. I don't want muckin abaht wiv me water or blood pressure, and me beer and me fags and who me old man was." This is the type of man who would say to his wife if you wanted to examine her: " Those bloody doctors get their claws on you if they get the chance. You keep away from them my girl and get something from the chemist. After all they make up all the prescriptions, so they must know it all and what's more they do it for a whole lot of doctors not just one. He only wants to get you undressed and paw you over. I've read all about them, the dirty bastards. Struck off I reckon he'll be before he's done." This may be a far fetched example, but how many feel it and do not say it?

A reaction of class suspicion does not occur where there is mutual confidence born of long familiarity, but with a new or unfamiliar patient, if only the doctor can see ahead the possibility of resentment at intrusion into a man or woman's privacy, then he can usually overcome it with tact. A few days' delay may not make much difference in the long term, but may be of great use in regaining confidence: " We'll try this, and if it doesn't get better, come back in a week and we'll try to find out what's stopping it from healing ". When you ride a horse you have always to have your eyes and ears alert so that you receive a warning of anything that may frighten the horse. *See the bogey before he does:* much the same applies to a touchy patient.

However well you know your patient, you are in difficulty if you suspect serious illness as the result of a minor symptom or sign, for the very mention of 'further investigation' gives you away, and with so much publicity of cancer nowadays, that is the illness which springs first to the mind of most patients. The trouble is that once that suspicion has been lit it is difficult to extinguish, and although the disease may not be, the anxiety remains. Delay in getting an outpatient appointment can be most harmful, here again a friendly husband can suddenly become an aggressive nuisance: " You think it's cancer, doctor. Well send her straight to hospital—ought to have gone long ago. When's she going? Don't you bother about having tests done first, they'll do them there if they think so. Two months wait? Listen son, I'm taking her tomorrow and I'll report you "; and he will go home to take it out of his wife who may only be suffering from symptoms of domestic stress, and who, as a result of your conscientiousness, now has a hornet's nest about her ears.

What to tell

This leads to the equally important question of what to tell, how much to tell, and to whom one should tell it? We all have our own ideas, based partly on temperament and partly on experience. I knew an elderly doctor who said to me, " Always give a bad prognosis, my boy. If you're right they think you're clever. If you're wrong they're only too pleased anyway." And another who gave me exactly the opposite advice, " Always leave them hope, my boy. When you can't give them any other medicine, hope will still do wonders." So where are you?

One must be honest, and I do not like telling a direct lie. On the other hand, it is not always necessary to tell the whole truth. If I don't know, I say so, but like to add, " but I will find out " or " but I will send you to someone who will find out ". To the question " Is it cancer? " I like to say " I don't know," or " I don't think so, but it is a condition which if not treated now could possibly develop into cancer later on." It gives me an escape clause, for which I am sometimes glad afterwards.

With incurable disease the relatives will nearly always ask for a prognosis in time. I think all of us on occasions have been wildly wrong. I remember especially two patients:

One was a comparatively healthy man in middle age who was found at an insurance examination to have a very high blood pressure. He had a trace of albumen in his urine, and doubtful changes in his fundi. I felt it to be my responsibility to warn his family and we had long discussions. In the end he wound up his affairs and left his business, sold his house, and emigrated to Canada to live near his married daughter. Twenty-five years later she wrote to a friend to say that he had just died, having enjoyed the best of health, and his doctor having said that he finally died of " low blood pressure ".

The other patient was an elderly man who had a massive stroke and lay unconscious. He was thin, old and emaciated, and the relatives were sensible, and merely did not want him to suffer. He started Cheyne-Stokes breathing after three days, and I felt confident in saying that another two or three days should see a peaceful end. He went on for over a fortnight, even then we kept on expecting him to start breathing again, even when we knew he could not possibly do so.

Terminal care at home

The doctor is not only treating the dying patient, but he has to bear in mind the anxious relatives who are undergoing a most difficult time. Watching from the side-lines, it is fascinating to see how deceptive appearances can be. The couple who have lived a cat and dog life for many years, with neither of them ever missing an opportunity of a dig at the other, may appear now in a completely different light: it can almost be said that this aggressive relationship was their way of showing deep attachment and affection: it can be judged by the desolation of the lonely remaining sparring partner.

The doctor's duty is to see that the patient has as easy a passing as possible—this sometimes conflicts directly with what he has been taught about therapeutic doses. This is a matter of personal behaviour and conscience, but I have always felt that the right

dose of painkiller is the smallest that really works, though this may be much more than what the textbooks give as the maximum. As the dose is bound to escalate the longer the patient remains alive, a nice judgment is needed not to start heavy doses too soon.

The humanistic approach

The place of the doctor has radically changed since Victorian times, then he was the father figure, his authority and his skill were unquestioned, and it was he who " ordered the patient to do this and that ". We know that much of the dogma on which he quite honestly based his portentous opinions is now almost ' a load of old rubbish ' from the strictly scientific point of view, yet it was often enormously successful when employed with skill and tact. It gave the patient confidence so that nature was allowed to effect a cure unhampered by anxiety and depression. I think it was Charcot who said, " God drives the carriage with the invalid in it, I only run beside it and cheer."

Yet with the explosion of scientific discovery in the early part of this century, there was a tendency to become mechanistic, and I was encouraged, as a student, to apply a strictly scientific attitude to medicine. I had to question, prove, test, my diagnosis with x-rays and laboratory investigations, with blood counts or with an electrocardiogram. Having arrived at a diagnosis, the treatment then was automatic, use drugs and the correct régime to promote healing in the offending system of the body, and—" Bob's your uncle! " However, *the person behind the patient* was neglected.

In those days, the medical student saw nothing of medicine as practised outside the hospital, his cases were bed numbers or outpatient folders. When I went straight into general practice I found that mechanistic medicine did not work, and my job as a doctor was leading me down strange paths. I found that I was sometimes a crutch, but more often a waste-paper basket: and I even found myself in the unenviable position of being the rope in the tug-of-war between husband and wife, or an Aunt Sally for temperamentally aggressive types.

So it was back to the humanistic approach, which is the essence of a doctor's responsibility. Osler said " If you listen to your patient he will tell you what is wrong "—for the greatest need in practice is for someone who can listen patiently, and often people choose their doctor for this reason alone. The problem now is in organisation; to give enough time and uninterrupted attention to this most important involvement between doctor and patient.

There is a built-in danger in this relationship, for there is a boy scout in all of us and we have to be careful to respect an individual's freedom of choice even when it means that he will reject what we think is good advice. Should we let him go to the devil in his own way? I am thinking of alcoholics, compulsive eaters, heavy smokers: I feel we must limit our responsibility to telling the patient plainly what it is that he risks and leaving the choice to him, without undue blackmail. I have had a patient who thought my sermon was unnecessarily pompous, and who said, " Thank you for your advice, and you know what you can do with it! "

We must also remember that involvement with the doctor may be the sole object of the patient's visit. He wants help in an intolerable situation, friends and family seem unable to give it to him, and he turns to the doctor, as in the old days he would have done to his priest. His difficulty is that tradition demands that he should go with some physical complaint and so he will present with some minor triviality which is far from the real object of his visit, and, if the doctor takes this at face value, he will reassure the patient that there is nothing amiss, and fail him. How can one avoid this? It is all a question of time. The patient may make a last despairing effort with his hand on the door after you have rung for the next appointment, " Oh, and by the way doctor, while I'm here . . . " when you hear that, you know that you are getting to the heart of the matter, and you

must strike while the iron is hot, while his courage is screwed up—ask the next patient to wait.

Included in the overall duty of a family doctor, there are two particular instances of responsibility to the individual; one is to the patient when he is in hospital but not under the immediate care of his general practitioner; and the other is to the patient by virtue of the doctor's personal knowledge of his heredity and environment, and hence his likely weak spot either in the physical or mental composition.

The patient in hospital

It is tempting for a busy doctor to feel that, once his patient is in hospital under a consultant, his individual responsibility ends until the patient is discharged. And yet—patient and relatives are suddenly on strange ground, they have to make contact with new people—nurses, house officers, and consultants. They have anxieties and questions which matter tremendously to them, the hospital staff are equally at a disadvantage for lack of knowledge of the home conditions and education and temperament of the patient lying in the bed. In the early stages after admission to hospital the family doctor should follow his patient into the hospital, to answer the questions so far as he can, to tell the sister the little vital details: the woman is worrying about her husband and the woman down the road; about little Johnny being led astray by those school friends of his who throw stones at railway trains; or about what her daughter is doing with her boyfriend when mum's eagle eye isn't on her. Only the general practitioner can tell the consultant the suitability of the home conditions for discharge: " send him out as early as you like, he's a sensible chap and there's plenty of help at home "—or the opposite—" he'll go back to a slum and have to make his own bed and empty his own slops ": or about the housewife who has finally broken down by the sheer weight of overwork and worry, and who must have a little extra breathing time before she can cope with life again.

In modern medicine there has been such a divergence between general practitioners and consultants that the family doctor no longer goes into the hospital automatically to look after his own patients. He has neither the special skills nor the facility, but this does not mean that he should cease to feel responsibility for that side of his patient where he can still help so much. Where he has a clinical appointment in the hospital, he can make a point of visiting the inpatients on the days when he has to attend there, but it is with the doctor who has no regular appointment that I am dealing now, and he should set aside a regular time each week when he visits the hospital to see his patients; so often there is a clinical round or demonstration in the postgraduate programme, and he should allot extra time for visiting the wards. He will be well rewarded by the patient's eyes lighting up when he sees who it is that has come to visit him. There is the whisper to the bed next door " That's my doctor come to see me." Wise nursing staff always welcome him for the good that he alone can do to the patients in their wards, perhaps quite simply because he knows their wavelength. All communication depends on two people each understanding what the other is saying. Some consultants are very good at gauging the mentality of the patient; however, a high-powered clinician and a farm worker's wife may have almost nothing in common and it is in these situations that the family doctor can help. Patients will ask him questions which they dare not ask the hospital staff.

Besides visiting his patients in hospital, it is the responsibility of the family doctor to select the consultant who is most likely to get on with his patient. It is not enough just to refer him to the appropriate outpatient department, a conscientious doctor likes to know his consultants personally, and where possible to match the two together and to avoid a clash of personalities. From his knowledge, he should be able to give the consultant the kind of information that he likes to have, the results of investigations up to date, what treatment has been tried, how much the patient knows, and what he expects from the

consultation. Best of all is for the general practitioner to be present at the consultation, allowing free discussion between patient, consultant and doctor. The disappearance of this genuine consultation is a retrograde step in practice.

Heredity and environment

It is our responsibility to know the heredity and environment of our patients. If we take advantage of the fact that more and more people can get to our surgeries, and neglect visiting them in their homes, we miss what may be a vital clue in illness. The longer a doctor stays in a practice, the more he will know about the parents and grandparents of a patient, the physique, the mental stamina and the weak spot which is liable to give way under stress. From the home conditions he will also know what stresses there are, and the knowledge will not only help him, but also can be passed on usefully if he has to send his patient for a consultation. Respect for this particular responsibility is the mark that distinguishes the proper family physician from the ' clinic doctor ' and the impersonality that that name implies.

Chronic patients and labels

There is another responsibility which some doctors tend to regard as an unnecessary burden—the chronic patients. These are usually people suffering from degenerative diseases for which there is no cure, only relief which does not require much supervision. At the same time these people probably feel more than anyone else the need to be looked after and not forgotten: they always have some aspect of their complaint for which discussion with their own doctor is the sole outlet. Practices vary, some doctors visit chronic patients regularly about once a month, others will say at the end of an acute episode " Well, let me know if you're not getting on " and cross them off the visiting list. I feel strongly that the former is the correct way of taking responsibility for these unfortunate people.

Problems of old age

So many of the natural diseases of old age, which formerly were mortal, respond readily nowadays to antibiotic treatment. If we prolong life beyond its natural end, we should accept the responsibility to make that life tolerable, and this involves both the patient's family and his doctor, for, although the patient appears to have made a good recovery, illness always leaves its mark and especially with the elderly who suffer from the degenerative diseases.

In the early days of penicillin, an elderly farmer friend of mine developed pneumonia, and would have died in the ordinary way. He had been an active old man, about in all weathers with one, two or even three sacks tied or draped over his body as protection against rain and wind. I enthusiastically gave him penicillin, and he came through—but to what? His daughter used to push him out in a wheel chair, white faced and apathetic, otherwise he dozed off while he watched the cricket or tennis on the television. Two or three years later he got pneumonia again, and his daughter drew me aside and said to me " You won't give him penicillin again will you doctor? "

Old people are notoriously crotchety, bad tempered and complaining. This is natural, who welcomes increasing disability? So often there is still a young and enterprising mind imprisoned inside the decrepid body, and frustration is the main feeling in their lives.

An attractive woman had her elderly mother, a quite impossible old lady, to live with her. Once when she had been appallingly offensive in my presence, I asked the daughter how she could tolerate it. She replied: " When mother was my age, she was beautiful and gay and she enjoyed life. She had money and enjoyed everything—travel and wine and food, good company and lovers. Now what has she left? I think her only pleasure is to take the mickey out of me, so bless her, let her have what's left."

Many old people restrain their feelings with their own family out of gratitude and even as a good policy; but they must have a safety valve, and a doctor is as good a punch ball as any, and we can feel after a particularly disagreeable session that at any rate the

family who are shouldering all the burden can now have a little peace for a while. Quite apart from this it is the personal attention and the chance of giving them some fresh help in coping with their disability which the patient appreciates. It can be rewarding in a mundane sense: my old predecessor when he handed the practice over to me said " Be good to your old chronic patients, because it will pay you. People think of them as experts when it comes to illness and doctors, and if they give you a good word, you'll be made! "

I think we should go further and regularly re-assess the patient, disregarding any preconceived diagnosis or label which has been firmly attached to them. A visit by a partner for a change may change the picture, as I found long ago when I came back from a holiday to find that an enthusiastic young locum had re-labelled a number of my chronic patients, greatly to their advantage. A 'chronic gastritis' had had a blood count and was a pernicious anaemia, an elderly 'bronchitic' had his sputum examined and was found to be a smouldering case of tuberculosis. One danger of the label is where a request for medicine is made by telephone for a diagnosis that has been made by the patient or a relative, or for a repeat for the labelled condition.

The most dramatic example I remember was at the end of an evening surgery, when I was asked to put out some medicine for a boy of 16 who, his mother said, had a very acute attack of diarrhoea and had fainted on the lavatory. " Would doctor just put something out to settle his stomach and then if he isn't better I'll let you know in the morning? "

As we grow older there is a little red light somewhere at the back of our brain that switches on unconsciously, and it glowed on this occasion. What was it? The penny dropped, for both father and grandfather had in their time had haemorrhages from peptic ulcers. Could it be occurring as early as this in the son? I went to see him, and sure enough there was the black faecal stain, black faeces on my rectal examining finger, and a blanched boy with a pulse of 130 was operated on that evening for a bleeding duodenal ulcer.

Another example is the common and misleading label of cystitis for a middle-aged woman, which should be checked *ad nauseam* by the pathology laboratory for evidence of infection; it so often is merely the call for help when things get too much in the domestic or emotional life.

Rota systems

The rota system poses another problem to the conscientious doctor—how far should we delegate our personal responsibility? One winter I was called out at 02.00 hours with snow on the ground and a freezing fog. I had influenza, and so had the two other doctors in the town. I met both their cars crawling out to the same village on that one journey, and a day or two later I met them and suggested a rota system at night. The older of the two, who was a sick man, and who died a couple of years later, was all for it, but his younger partner said, " I couldn't sleep happily if I went to bed feeling that one of my patients was in need of me and had to put up with someone else, however good he was." There is a danger here of excessive possessiveness. At the other extreme we all know of the doctors who live well away from their practice, lock up their premises after the evening surgery, and hand over to a locum service. In between these two is the commonest arrangement of a rota system between small groups of doctors who know and trust each other, and who may even know each others' patients quite well. If the patient has been seen by someone else during the night, should he be seen again next day? If we are as conscientious as all that, does it not defeat the whole object of the rota system? This is the kind of problem which a sense of responsibility brings.

Professional secrecy and confidence

Another closely allied problem is that of the conflict between the law and professional secrecy. I am thinking of epileptics, and diabetics, and patients on drugs which affect their judgment when driving cars or handling dangerous machinery. There is the patient with impaired vision, or with reactions which are slowed either by nervous disease or by

disability of his limbs: yet all these will cheerfully drive and may be a serious threat to the life and health of others.

It is our duty to tell these people the risks that they run, not only for themselves, but for other people. More often than not this advice will be resented, even if the patient feels guilty enough about it, to the extent of a change of doctor.

There is also the problem of professional confidence in the case of parents and adolescent children which has recently been highlighted by the General Medical Council. You may know that a child is on drugs, or that a girl is getting supplies of contraceptive pills, or is having treatment for venereal disease. The children in their very trust of you feel safe; but what do you do if the parent asks outright about the child? The least you can do is to ask the young man or woman if their parents know anything about this, whether they ought not to tell them, *and what they expect you to do if asked a direct question*?

Quite a different conflict used to be more common than it is now, namely the 'death bed promise.' This was usually made by a single daughter to a dying parent, that she would not go away (i.e. marry) but look after the remaining parent. I always thought that this was wicked, and have in my time said so when I have been appealed to by an attractive young girl breaking up a happy engagement and everything which that could bring, because her parents took selfish advantage of the fifth commandment.

As time goes by, the relationship between a patient and his doctor settles into a particular pattern. In some it may be dependence, or respect, or aggression, it varies with the patient. But we must treat each individual according to his particular relationship, and not forget.

A teenage farmworker whom I had known since birth came to see me one evening. I did not recognize him until I looked at the name on his notes, then I remembered him as an ordinary schoolboy, but here was a young man in a mauve shirt, a leather jacket, tight pants and winkle-picker shoes—the lot. After I had dealt with him, I said "You know I didn't recognize you in these extraordinary clothes, must you wear them?" I saw in his eyes the hurt look of a dog that comes up and puts its dirty paws on your clean clothes and gets his nose rapped in exchange for his affection. "But doctor these are my best clothes, I put them on specially to come and see you."

This hurt look can be seen in the tired housewife at the end of her tether, who comes with some trivial ailment, and is brushed off quickly to make time for the next patient; when in reality she has screwed up her courage to come and try to get relief for an intolerable situation, but has to select some passport for the receptionist for an appointment.

Equanimity

The happiest state in which a man can live, whether he is patient or doctor, is that of equanimity. We see it in some of our friends and some of our patients, and envy them: but if we analyse their individual conditions, it often transpires that it is not an equilibrium which is due to inertia. In physics a body may stay still in two situations: first there may be no stresses in any direction, but that is something which does not occur in this life except perhaps in the distressing one of autism. The other situation is where stresses occur but in such directions and proportions as exactly to cancel each other out. In every man there are many stresses, and usually one or more will be more powerful so that it is rare to find this perfect equilibrium we call equanimity. The stress of a feeling of responsibility by a doctor for his individual patients may be extremely strong and sometimes distressing. When to deeply conscientious responsibility is added the normal pulls of family ties and the profound anxieties and sadness that these may so often bring, with financial worries, occasional poor health, the stress of too much work and too long hours, and of guilt when he fails a doctor may lose his equanimity. It is then that he may crack, and his concern over his patient may defeat its own end. Responsibility must be kept in reasonable proportion for the good of both doctor and patient.

In this light it is interesting to see how patients react to their stresses according to their individual temperaments. On the one hand there is over-reaction to quite small stimuli, and on the other there is the patient who appears to remain serene under the most distressing circumstances. It is not so much what happens to a person that matters but how he takes it.

This inner strength may be temperamental, but it may equally be part of profound religious faith, or of a philosophy of life, as when Polonius said to his son:

> " This above all. To thine own self be true,
> And it must follow as the night the day,
> Thou can'st not then be false to any man."

In the same way, the family doctor must set himself a standard which only he can satisfy and which he always seeks to criticise; responsibility for his patients is an essential part of this standard. When in doubt how to act, a doctor can often be guided by putting himself or his family in the patient's place.

In the end, there is no clear demarcation of the responsibility of the doctor to the individual patient. There is nothing to say where it begins or where it should end. We learn more by our failures than by our successes. I think it is a matter of committing, not only our medical skill, but ourselves as one human to another in need.

REFERENCES

Browne, K. & Freeling, P. (1967). *The Doctor–Patient Relationship*, Edinburgh and London: E. & S. Livingstone Ltd.
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SPRING MEETING

The Spring meeting of the College will be held in Liverpool on 7–9 April, 1972. There will be a civic reception at the Town Hall, Liverpool at 20.00 hours on 7 April. On the following day there will be a symposium *Advances in Treatment* chaired by Lord Cohen and Lord Rosenheim. The speakers will include Professor A. C. Kennedy, Dr I. Greig and Professors D. J. Wetherall, C. A. Clark and J. D. E. Knox.

There will be a reception and faculty dinner on Saturday evening and a programme for visiting ladies and children during the day on Saturday. The William Pickles lecture will be delivered by Dr R. P. Maybin on Sunday 9 April, his subject being *Health centres and the family doctor.* Ample accommodation is available in halls of residence but hotel accommodation is expected to be limited. Members attending should apply immediately to the Organising Secretary, Waterside Lodge, Barrel Well Hill, Chester.