RCGP William Pickles Lecture 2017:

A new kind of doctor

THE MYTHOLOGY OF GENERAL PRACTICE

For the last decade, I've been a doctors' doctor, leading a confidential service for doctors with mental health problems, the Practitioner Health Programme (www.php.nhs.uk). In caring for my own kind, I've tried to understand why I'm seeing growing numbers of mentally ill doctors. I will suggest, as Julian Tudor Hart did in the 1980s,[1] that we need to train 'A new kind of doctor'.

During my life, three GPs have been important influences. The first is my father. An immigrant to the UK in the 1960s, he was a single-handed GP in the East of England. Our home was his surgery; our front room doubled as the patients' waiting room and our dining room as his consulting room. From an early age, I saw first hand the relationship my Dad had with his patients. His dedication, his authority — and his love. When I was a young girl, he would take me with him on home visits — and I was enthralled as he explained what the house call was all about. He enthused me with a love of medicine and, more importantly, a love of general practice.

The second is William Pickles, the first president of the RCGP. Pickles was the archetypal family doctor.[2] He too lived above the shop — in the doctor's house with his practice partner, an old friend from medical school. Like my father, he was known for his kindness and knowledge of his patients. By the time he died, at the end of the 1960s, he'd already become part of general practice's mythology.

To these two I add a third, Dr John Sassall, who was the protagonist of John Berger's 1967 book *A Fortunate Man: the Story of a Country Doctor*.[3] Sassall worked in the Forest of Dean, and, in Berger's fly-on-the-wall account, emerges as someone who embodies all that's best about our profession. He's described as

'... all-knowing ... haggard ... and accepted by the villagers and foresters as a man who, in the full sense of the term, lives with them'.

Stories like these have contributed to the folklore of our profession but I believe we are in danger of looking at the past through rose-tinted spectacles. Building a future on the foundations of a distorted version of the past makes life difficult for this, and the next, generation of GPs.

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CRITICISMS OF PAST PRACTICE

A more dispassionate view exposes the realities behind these stories. Like my father, Pickles also took his daughter on home visits. There is a record that he even took her to visit a dying woman. By taking their daughters on home visits, both Pickles and my father could be accused of putting their needs, and those of their family, ahead of their patients.

Pickles practised during the 1950s, when Joseph Collings surveyed 55 randomly chosen practices and reported finding:[4]

'... practices with minute consulting rooms with no chair for the patient and no couch for any examination; queues extending 200 yards waiting to see the GP; a practice of 4 principals and an assistant seeing 500 patients per day and proud of it; waiting rooms where patients had to stand for hours before being seen for 5 minutes.'

The Taylor report, published in 1954, found wide discrepancies in the quality of care provided by GPs, and a stark contrast between what constituted 'a good GP' and 'a bad GP'.[5]

I'm sure my father's practice would have come in for severe criticism too. When he moved it to a two-up-two-down converted terraced house in the 1970s, the patients' lavatory was situated behind the only consulting room. When in need, patients had to walk through, interrupting the consultation. The sound of their bodily discharges was clearly audible.

And what about John Sassall? Like many of the doctors I see in my Practitioner Health service, being a doctor meant everything to him, so much so that he blurred the boundaries between his professional and personal lives, creating a hybrid identity, an amalgam of these two personae, which I call the 'medical self', a single identity, which can be thought of as the essence of vocation. As one doctor attending my service told me:

'... being a medic is not just a job that you go to, it is something you are'.

The medical self acts to mask our suffering, protecting us from feelings of guilt, fear, and hopelessness. However, it can, and often does, get out of hand, especially when not counterbalanced by a healthy working environment or personal support. Sassall, like so many doctors attending my service, defined himself by his work. When his long-term practice partner died, instead of acquiring a new one, he chose to split the list and run the practice single-handedly. Sadly, after the death of his wife, things became too much for Sassall, and eventually he took his own life.

Which brings me to the subject of mental illness in doctors. Across all age ranges, in all health systems private or public, in all countries and across all specialties, doctors have higher rates of mental illness than an age-matched population. There are many reasons for this.

THE FORMATION OF THE MEDICAL SELF

From our first day at medical school we become special and begin to connect with

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the 'family' of medicine, past and present. Our specialness is reinforced during training, as the distance between us and our non-medical peers widens. Helped by our new scientific language, symbolically through dress — the white coat — and through the acquisition of the new title — doctor, our medical self is strengthened. With its strict hierarchies, expectations around behaviour, and professional solidarity, medicine sets us apart from others. Our medical self becomes enmeshed in the group of belonging — medicine. The connections formed by this group are vital if we are to survive a lifetime exposed to death, despair, and disability. The group also determines its own norms, which dictate certain behaviours, including the idea that we do not become sick. It is patients, on the other side of the consulting room, who become unwell — not doctors. In *When Breath Becomes Air*, the dying neurosurgeon Paul Kalanithi wonders:

'Why was I so authoritative in a surgeon's coat, but so meek in a patient's gown?'[6]

It is because as the complete object — the 'doctor' — we create an aura of invincibility around ourselves, and are not good at being patients.

There are other reasons why we are at risk. Doctors occupy a privileged position in society. We have status, expertise, and considerable power, and are granted access to the most intimate and secret parts of our patients' lives. But with these privileges come darker consequences. Patients confide in us. They tell us things they wouldn't tell anyone else, not even their closest friends or family. This can be a tremendous burden as we enter 'the swampy lowland' with our patients — a place of confusing 'messes' incapable of technical solution, as Donald Shön describes it.[7] To survive a life in medicine, we develop strategies to suppress our emotions by shoring up our psychological defences. However, the personality traits that make us good doctors — obsessiveness, perfectionism, even narcissism — can, when our backs are against the wall, turn into the compulsive triad of doubt, guilt, and an exaggerated sense of responsibility.

RISING MENTAL ILLNESS AND THE BURDEN OF EXPECTATIONS

There is a sense that the increase in mental illness among doctors is due to the current generation being less resilient than previous ones. There is no evidence for this. Resilience is about bending with pressure and bouncing back. But, given the wrong circumstances, each one of us has our breaking point beyond which we cannot go, and it was always thus. The rise in mental distress among doctors is made worse by my generation clinging to a distorted view of a golden past that never was, placing an enormous burden of unrealistic expectations on the shoulders of the current generation of GPs.

We reminisce about continuity of care and the freedom to do what we felt was right for patients — unconstrained by the demands of a marketised healthcare system. What we don't mention was the paternalism, the bullying, the long hours, and how junior doctors were left unsupported, expected to do most of the work on their own.

GPs make a valiant, but futile, effort to live up to an impossible standard, measuring themselves against medical heroes — like Pickles and Sassall — who, on closer inspection, are themselves revealed to have feet of clay. Facing up to the realities of our profession's past helps us see that those who came before us were no better, and no worse, than we are today.

A NEW DEFINITION OF BEING A DOCTOR

Despite the difficulties we currently face I believe there's never been a more exciting time to be a GP. But in future doctors will have to challenge some of the assumptions that have been made on their behalf. Of course, doctors should always act honestly, compassionately, and avoid conflicts of interest, but is it reasonable to ask newly qualified doctors to consecrate their life to the service of humanity? I believe we need a new definition of vocation, adapted to the times we live in. One that reflects the fact that we are all human beings trying to do the best for our patients.

If we expect doctors to give their all to others, then the *quid pro quo* is that we have to protect the doctor — and the connections that sustain them. Protected spaces free from the clutter of inspection, assessment, or monitoring.

The new kind of doctor must think about their own needs if they're going to be able to do their best for patients. This is not about denying the needs of the patient. But self-sacrifice is no longer an option. It's bad for doctors. And what's bad for doctors is bad for patients too. When the system demands too much, the doctors of the future must be encouraged to say, *'No more!'*

The myths of our profession do little to help those who find themselves in turmoil. In truth, they make things worse by promoting unrealistic expectations of what a 'good' doctor should be. Of course we must take the best of the past but we can only move our profession forward by looking to the future, not back to a golden age that never was.

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Provenance
Freely submitted; not externally peer reviewed.

Competing interests
The author has declared no competing interests.

Further information
Clare Gerada's RCGP William Pickles Lecture 2017 is available at https://www.youtube.com/watch?v=9F7-RbS9q8Y (accessed 5 Sep 2017).

DOI: https://doi.org/10.3399/bjgp17X693017

REFERENCES

1. Hart JT. *A new kind of doctor*. London: Merlin Press, 1988.
2. Pemberton J. *Will Pickles of Wensleydale: the life of a country doctor*. London: Geoffrey Bles, 1970.
3. Berger J, Mohr J. *A fortunate man: the story of a country doctor*. Edinburgh: Canongate Books, 2015.
4. Collings JS. General practice in England today: a reconnaissance. *Lancet* 1950; **i:** 555–585.
5. Taylor S. *Good general practice: a report of a survey*. Oxford: Oxford University Press, 1954.
6. Kalanithi P. *When breath becomes air*. London: Vintage Publishing, 2016.
7. Schon DA. *The reflective practitioner: how professionals think in action*. New York, NY: Basic Books,1983.