Out of Hours

Where do we go from here?

Caring versus the system

At the inception of the NHS, junior house doctors were expected to use all the laboratory, X-ray, and bacteriological services of the hospital. When those same doctors went into general practice they were totally cut off from the hospitals and restricted to making bedside diagnoses. When I became a GP in 1954, if I wanted to know the result of a chest X-ray or even a full blood count, I had to send the patient to a consultant in out-patients where the investigation would be ordered. GPs had no status within the profession, were on duty 24/7/52, and were expected to care for 4000 patients. We needed an academic college of our own. It was founded 60 years ago.

I applied for membership 55 years ago, just too late to be a founder member, and was asked to attend for interview. I can tell you it was far worse than any exam I had sat. In front of a row of my peers, the pioneers, really notable doctors, I was asked:

- Why did I want to join the College?
- What did I think the aims of the College should be?
- How could those aims be achieved?
- What did I think about GPs becoming teachers?
- Was I prepared to be active within the College and if so, how?

Every answer I gave was thrown back at me for justification and enlargement. I must have given enough convincing answers for I was elected to membership but asked not to use the letters MCGP after my name.

Since then the College has grown in strength and stature in a way that could only be dreamed of in those early days. We have secured our status within the profession, we have become university teachers, we have achieved a proper level of pay, and hours of work. All this we have gained, but

unfortunately we have lost some things too. Perhaps the greatest of our losses was the affection of our patients. We may still even now have their respect, but not the warmth, friendship, and emotional component of the old doctor-patient relationship. It may have been changing our hours of work that scuppered it. Anyone who works from 9 to 5 has a job. Doctors were never thought of as having jobs. Like priests they were perceived to have a calling. So one can hardly blame the public for grumbling about a doctor not doing his job properly resulting, as Gerada and Riley wrote in an editorial in the 60th anniversary edition of the Journal, '... we are under constant threat. Barely a week goes by without another report implying that GPs have failed in some way.'¹ Does this also suggest we are now losing our patients' trust in us?

So where do we go from here? What can we, as GPs, offer, that other doctors, confined to their super knowledge of one organ or one body system like hepatology or immunology, cannot. What is it that we uniquely offer? We are not, and should never pretend to be, mini specialists in all the other branches of medicine, although we must keep up-to-date with advances across the spectrum of technology.

I suggest that, in addition to our recognised value as the first port of call for patients and the treatments we are able to offer, there are three things we should recognise as special to us.

First: prevention. This includes all the childhood and other vaccinations, obesity, the complications of existing conditions, contraceptive advice, and so on. It is not enough just to do it. It is like justice; it must be seen to be done. It has to be advertised to patients with notices in waiting areas, leaflets sent with any correspondence, and so on. If left to the initiative of the patient, this fundamental aid will largely be lost.

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Second: early diagnosis (carcinoma, breast, Alzheimers, and autism) and active searching for latent illnesses such as hypertension, hypercholesterolaemia, and osteoporosis. When patients attend for one condition it is the ideal time to think laterally.

Third: understanding. We are the ones who must understand that the patient's illness in the setting of their family is different from the consultant's view of them in the isolation of a hospital ward among strangers. We are the ones who must fit the patients' illness into the pattern of their life. We are the doctors who must understand that the presenting symptom may mean one thing to us but something different to the patient. Our sympathy for the patient is different from the sympathy shown by consultants.

None of these is exciting and cannot match the drama of, say, open-heart surgery, but collectively they are far more important for the health of the nation than the excellent work done by our specialist colleagues. And if we do not do these things, we could just as well be replaced by computers.

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REFERENCE

1. Gerada C, Riley B. The 2022 GP: our profession, our patients, our future. *Br J Gen Pract* 2012; **60(604)**: 566-567.

We are looking for some new columnists for the Out of Hours section of the BJGP

Fresh

Provocative

Lateral-thinker

1 out of 3's not bad • 2's good
• All 3, you've sealed the deal

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Euan Lawson, Deputy Editor