Out of Hours
My introduction to general practice:
a steep learning curve

I graduated MBChB (VU Manc) in 1950 and was very lucky in my first job to be appointed house physician to the great Dr Henry Howat at Ancoats Hospital. Dr Howat was the ultimate clinician, driven by an enquiring mind, an encyclopaedic knowledge, and a very high standard of ethics, and he expected a similar discipline of mind from me. Although my official title was house physician I soon discovered that I had many other duties, including administering anaesthetics for the gyny list once when the anaesthetist was ill, acting as medical admitting officer at least once a week, and doctor in charge of the casualty department also at least once a week.

I shall remember for the rest of my life one particular night in November 1950 when I was on casualty duty. I had just X-rayed a patient's arm in the X-ray department, developed and dried the film, confirmed a fractured ulna, and was setting the arm in plaster with the plaster sister, when a GP rang to ask me if I would see a patient with a fractured femur.

'Of course. Just send him along', I said happily, and although I hadn't the expertise to treat a fractured femur I thought I had better see the patient first before sending for the orthopaedic registrar on call. And I thought no more of it. Until the patient arrived. Then, my eyes almost popped out of my head. Covered with blankets, blue in the face and severely dyspnoeic, he walked with the ambulance driver's help into the casualty department. He walked! Walked! He was supposed to have a fractured femur! Quickly I opened the letter from the GP hoping it would shed some light on the discrepancy but it simply read: 'Thank you for seeing this patient.' At first I was nonplussed and didn't know what to think but it only needed a brief bedside examination to make the diagnosis of right lower lobe pneumonia — with dullness to percussion, prolonged expiratory sounds, crepitations, and whispering pectoriloquy — all the classical signs. Yet the GP had asked me to see a patient with a fractured femur! It didn't make sense. What kind of a GP was this? I began to seethe.

'Let's see to the patient first', night sister said to me, judging my reaction perfectly. The trouble was we had no beds. We couldn't send the patient back and our only course of action was to put up a bed in the middle of one of the male medical wards. Having done

> *"Would I have let my patient die alone in a cold, damp house with no one to love him, or would I have resorted to unethical subterfuge?"*

that and started treatment, I rang the GP. By this time I was more then seething: I was fuming, I was aggressively furious, I was everything in *Roget's Thesaurus* under the heading of 'Indignation'. He answered the phone and I attacked him without even giving him a chance to explain himself. What kind of a doctor did he think he was? You didn't even have to be a first-year medical student to know the difference between a fractured femur and right lower lobe pneumonia. No wonder GPs were considered the dregs of the profession. Lord Moran had been right when he described GPs as doctors who had fallen off the consultant ladder. On and on I went until my bile was exhausted. The GP never interrupted. Never said a word. He just let me go on and on until finally I said to him, as if he was a naughty little boy, *'Well! What d'you have to say for yourself?'*

There was quite a long silence, or so it seemed to me, before he said, *'You're very young, aren't you?'*

'What's that got to do with anything?' I retorted, even more irritated.

'It's got to do with that poorly understood word: experience', he replied.

I have to confess he had a lovely voice, soft and gentle, even fatherly, but that was not going to soothe my animosity.

'Now look here doctor,' I said, *'experience doesn't come into it. Either you can diagnose a right lower lobe pneumonia by the bedside, as I just did, or you can't. If the patient hadn't been so ill I would have sent him back to you ...'*

'Precisely,' the doctor interrupted, *'and I daresay you had to put up a bed in the middle of the ward because you're full.'*

'As a matter of fact that's exactly what we had to do', I said.

'And so,' he continued, *'if I'd asked you to accept a patient with a right lower lobe pneumonia you'd have refused.'*

'I would have had to refuse', I said. *'We were full. It would have been a genuine refusal.'* *'Of course,'* he said, *'and so were all the other genuine refusals.'*

'What other refusals?' I asked.

His voice never changed. It was never aggressive, never superior, never conciliatory, never condemnatory, but always soft, gentle, and understanding.

'I have spent the last 2 hours on the phone', he said *'trying to admit my patient somewhere. I have phoned every hospital from Bury to Wythenshawe. I have phoned Salford Royal, Manchester Royal, Hope, Withington, and always met with the same reply from every RMO — we're full. Try somewhere else. Ancoats was my last hope. I was not going to fail my patient. I'm sorry I resorted to subterfuge. I do most sincerely apologise to you.'*

There was a brief silence and then he continued. *'I suppose you must think very poorly of family doctors. No doubt you have just graduated from a prestigious university and know all the latest research, but I assure you I am quite capable of diagnosing pneumonia in all its forms. And if you think I'm unethical and underhand, badly educated, and not worthy of the professional title of "doctor", then that is the price I have to pay. But for me, I shall sleep happily and content in my bed tonight because I know I have saved my patient's life. That lovely old man you just admitted lives alone in a cold, damp house with no heating except for coal which he can't carry, no one to feed him, no one to care for him, lonely and depressed following the recent death of his wife. You see, doctor, there's more to be considered than just the pathological diagnosis.'* He paused and then said, as if he was a friend, *'I wish you a very good night.'* And he put the phone down.

At Christmas time, as many patients as possible were discharged home to spend the festive season with their loved ones. That left a lot of empty beds and the hospital invited previous patients, known to live on their own and have no immediate family, to fill those beds and join in the festive atmosphere of the hospital. The resident doctors and nurses put on a pantomime and Dr Howat himself came in on Christmas day to carve the turkey. One of the patients invited to spend Christmas with us (I always think of it as 'us') was the old gentleman whom I'd admitted with pneumonia the previous month. He had made a good recovery and I'd clerked him

Out of Hours
RCGP Annual Conference:
a reflection on reaching beyond the mask

ADDRESS FOR CORRESPONDENCE

Stanley Jeffs
3 Warwick Crescent, Stratford-upon-Avon, CV37 6YP, UK.

E-mail: stanleyjeffs@yahoo.co.uk

out to his family doctor in a not unfriendly letter. In fact I'd thought of his family doctor many times since then and wondered what I'd have done in his situation. Would I have let my patient die alone in a cold, damp house with no one to love him, or would I have resorted to unethical subterfuge, risked my professional reputation — or what? In fact I'd come to think of this family doctor as a very brave and honourable man, a man who put his love for a fellow human being above the accepted standard of ethics of his time. And as a result, unintentionally but happily, we, the family doctor and I, had kept the whole incident out of the public eye. What headlines it would have made in the *Manchester Evening News*, or even worse, *The Daily Express*: *'NO BEDS FOR THE DYING UNDER THE NEW NHS'* — or something like that.

On Christmas day after the turkey dinner, I went over to the old gentleman and said, *'It's nice to have you with us again, this time looking so well and healthy.'*

'Yes,' he said with a distant and slightly glazed look in his eye. *'It's much better this time.'*

'This time?' I queried.

'Yes', he said. *'This time. Last time they pretended it was a land fit for heroes but we all know it wasn't. But this time,'* he continued waving his arms in the air in an expansive gesture, *'this time, with an NHS for ordinary folk like me, this time there really is hope.'*

'I've never met your family doctor', I said, bringing his thoughts back to the present. *'Do you think you'd be able to tell me what kind of man he is?'*

'You mean what's he like as a doctor?' he said with clarity.

'No', I said. *'What's he like as a person? What's he like as a man?'*

'Well,' the old man said with a benign smile, *'I'd say he was the most gentlemanly gentleman I have ever met.'*

Stanley Jeffs,
Retired GP, Stratford-upon-Avon.

DOI: 10.3399/bjgp16X684073

I did not expect to find myself sat in a seminar room at the 2015 conference wiping away tears; I could tell I was not the only one.

Some say everything happens for a reason, and the session had just begun when I realised I was in the wrong room. As it happened, myself and a room full of GPs were given the privilege of listening to the real-life story of a patient journey told with such composure, courage, dignity, eloquence, and grace, despite the harrowing experience described, that I was completely humbled. The silence was pin drop as the audience was moved in a manner I am sure no one anticipated when taking their seat. On an unexpectedly warm day in Scotland, I was surprised to find I attended a conference wearing the badge of a professional-entitled 'doctor', to be mentally and emotionally jolted by a stranger, in a matter of minutes, to consider not only that role but also myself afresh.

It is so easy to hide behind that badge — to sit in a surgery and control your connection with the person sitting in front of you asking for help. To allow the scientist in you to overtake the humanity in you. To dissociate from the messy world of emotions and true empathy. I have been guilty of that more times than I would like to admit, but in doing so let down not only those who come to seek assistance but also myself. We limit ourselves, and thus limit our patients.

This session at the RCGP conference showed the power of transformation possible for both doctor and patient within a GP relationship built on partnership and patience. As a formerly reluctant GP I know being a GP is not for everyone. However, in my opinion one of the greatest assets of the medical undergraduate curriculum is the time spent in primary care, if only students are open to harnessing the unique value and opportunities in this. As stated by Professor Frede Olesen of Aarhus University in Denmark in his inspirational lecture:

'... the value of the personal trusted doctor should not be forgotten in the medical community ...' and: *'society should learn that the doctor may often be a cheap, strong drug when patients must learn to cope with disease and symptoms.'*[1]

Primary care is the perfect setting for students to learn how to live comfortably with uncertainties. As the psychiatrist Stephen Bergman (using the pseudonym Samuel Shem) summarised in his controversial and still important book first published in 1978:

'Connection comes first. This applies not only in medicine, but in any of your significant relationships. If you are connected, you can talk about anything, and deal with anything; if you're not connected, you can't talk about anything, or deal with anything. Isolation is deadly, connection heals.'[2]

Which rings true regardless of specialty, but I strongly believe general practice is an ideal environment in which to develop and hone these skills.

As a practising GP (6 years post-CCT) I am beginning to understand how students may be supported in primary care, where opportunities abound to learn about such nuances, in the earliest stages of their medical career. The one piece of advice I would give is: please immerse yourselves in opportunities for learning in a primary care setting in order to enlighten yourselves.

If you learn to build relationships with patients, not to hide behind the mask of science, and to cherish your humanity even in the most discomfiting of moments, you and your future patients will most certainly benefit in ways you could not have envisaged.

ADDRESS FOR CORRESPONDENCE

Anujeet Panesar
Keele School of Medicine, David Weatherall Building, Keele University, Staffordshire ST5 5BG, UK.

E-mail: a.panesar@keele.ac.uk

Anujeet Panesar,
GP and Clinical Teaching Fellow, Keele University, Keele.

DOI: 10.3399/bjgp16X684085

REFERENCES

1. GP Online. *Time to recognise the healing power of the doctor-patient relationship.* http://www.gponline.com/time-recognise-healing-power-doctor-patient-relationship/article/1366816 (accessed 29 Jan 2016).
2. Shem S. *The house of God.* London: Black Swan (imprint, new edition),1998.