

Life & Times

All together now

THE DEVOTED FAMILY PHYSICIAN

Growing up in 1960s East End of Glasgow, our family GP was straight from the pages of AJ Cronin. Chain-smoking, single-handed and practising from a lean-to garage; his craggy smile, partly obscured by an ashtray mountainous with fag-ends, became visible at 5 yards through a thick carcinogenic pall. Rumour had it he'd once been a fine middle-distance runner but his face was hardly Seb Coe; more Glencoe really.

My mother lived by the dedicated doctor's word. The only advice I recall her ever declining was his suggestion that — being a rather introverted child — I would benefit from the close companionship of a pet. He prescribed a dog.

No animal lover, mum compromised on a goldfish. My equally solitary Goldie survived just a fortnight, taken to an early grave courtesy of my older brother in that awkward phase of tormenting younger siblings and torturing innocent creatures (he went on to excel in child protection). Silent, transfixed, I watched as he raised my goldfish in a gesture of 'Tonight little fishie, you sleep with the humans.' I wasn't too upset, well, Goldie and me never really bonded.

I was upset however, when many years later, corresponding with my old GP's family after his passing, I learned by a grim reply that my devoted family physician had lived the double life of a functioning alcoholic, frequently flirting with penury, and prone to violent outbursts that left his wife and children in fear and misery.

Perhaps just as well then that I never chose the rose-tinted, romantic life of the single-handed GP. For like many young doctors, I understood early on that such a choice carried with it the potential for loneliness, isolation, and evolution into a creature of outdated clinical habits. Less so



Doctor talking to female patient.

today perhaps for the few that remain, with so much on-line information and even more off-line assessment, though often these seem simply to add to the pressures of working life, wherever it is.

WE'RE WEAKER DIVIDED

Now, in a career twilight zone that brings more flexibility, I've been travelling to work in some of the more remote UK locations, sampling a little of GP life in the Northern and Western isles; a busman's holiday if you like among various island communities.

This itinerant, care-free island existence may not quite equate with my old GP's single life in a '60s council estate, though there are similarities. Not least an admirable patient stoicism, which can unfortunately manifest itself in adverse clinical outcomes — such as late cancer presentations — but which also comes with a deeper connection to the natural order, and an embrace of what might seem less but is often more.

Professionally, it has been very rewarding. I've met many inspirational doctors devoted to their scattered populations, typically

working in group practices, sharing the stresses of relative isolation and the rewards of greater independence. I've also tasted the déjà vu pleasures of actually meeting and knowing the district nurse, the health visitor, the pharmacist, the physio, the mental health worker, even X-ray staff — often just by popping next door.

By contrast, back home, working in Urbania, I've felt the frustration of patients who may enjoy easier high-tech secondary care access but who are often completely indifferent to their own GP's existence.

Now, I am not all getting starry-eyed and Dr Finlay. My island colleagues would be the first to disavow me of any rural idyll delusions. There is no consensus on what constitutes optimum GP practice, and that's because it doesn't exist. While some patients doggedly pursue a familiar face-to-face experience, others are just as comfortable with an extended-hours stranger, or even an app that gives instant therapeutic gratification. And therein lies the conundrum; for in primary care today, we have to deliver what can seem like several conflicted models of care.

The one constant that we can foster is collective working. Whether in individual practices or the latest incarnation of primary care networks; we all benefit from sharing good practice, bad experiences, and the professional burdens that populate everyday life. Some of us may hanker after a vague, fuzzy, and selective past, but for every stellar Tudor Hart embedded expertly within the local community, there were doubtless many lesser mortals, for whom, like my own childhood GP, it was all just too much.

So, we must always seek better and easier ways to work together, whether in remote isles or inner cities, and whether in real or virtual consultations. For of one thing we can be sure; general practice is not meant to be lived alone.

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