The Last, the Least, the Lonely and the Lost

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A MEMOIR OF MEDICINE, MEANDERINGS AND THE MARGINALISED

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To Mum, Dad and Gran, who encouraged
me to pursue my dreams

How a society treats its most vulnerable is always the measure of its humanity.

Matthew Rycroft

We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line.

Atul Gawande

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Chapter 1

The road less travelled

"Come back and see me when you've got yourself sorted out. I'm sure we will be able to find something for you." The interview was over, and the Regius Professor of Medicine dismissed me, his hand lightly touching my shoulder as he steered me towards his office door in Glasgow Royal Infirmary. Those 22 words from Professor Sir Edward McGirr would remain with me forever, etched indelibly on my temporal lobes. Would this be my epitaph or my inspiration?

It was a balmy summer day in 1973, and I was 24 years old, poised on the launching pad of my medical career. I was the first member of my family to have attended university. My grandfather, a riveter in John Brown's shipyard on Clydeside, had died shortly after retiring, his body worn out by decades of toil. My father, from a working-class family of 11 children, had left school aged 13 to support his widowed mother by working in a cardboard box factory. I had only rudimentary knowledge of the medical hierarchy, based on my experiences as a medical student and a neophyte junior hospital doctor, still to complete his first year after graduation.

Progressing stoically through the very traditional six-year curriculum, grounded in lectures, rote learning, formalised ward rounds and relentless

exams, I had emerged with First Class Honours. A glittering career lay ahead…..

The road map for aspiring medical men (74% of my class were male) in Glasgow in the early 1970s was well-established and clearly signposted. Those with ability and ambition jostled to start climbing the tall ladder towards the Holy Grail of a consultant post in one of the teaching hospital-based specialties – medicine, surgery, obstetrics or paediatrics. This would involve arduous years of being "on call," manoeuvering to secure the "right" training posts, and studying for terrifyingly competitive examinations (with pass rates of 30%) to attain Membership of the appropriate Royal College. Those who failed to reach the top of the ladder or who fell off *en route* could always become general practitioners (GPs), the other branch of the clearly bifurcated profession, which at that time had no formal training requirements. The ladder career pathway had always struck me as rather prosaic, more suited to house painters or circus performers than to neurosurgeons or cardiologists. However, it had been robustly promulgated by Lord Moran of Marton in 1958, just seven years before I entered Medical School. Formerly Professor Sir Charles Wilson, he had been Winston Churchill's personal physician and President of the Royal College of Physicians, and was a pillar of the medical establishment. He also had the nickname "Corkscrew Charlie" due to his skill in negotiations with the British Medical Association and the Ministry of Health.

General practice was not part of the six-year curriculum at Glasgow University Medical School when I was a student, although one year's instruction in botany and physics were essential components. The only concession to this branch of medicine, where half of the Medical School graduates would eventually end up working, was a one-week optional elective during the Easter vacation, that enabled a student to work alongside a GP in the community. Few took up this option, preferring a holiday or to "swot" for the next exam. Despite its lowly professional status, I was intrigued by general practice and seized the opportunity to learn more about it. I was fortunate enough to be attached to a single-handed rural practitioner in southwest Scotland. Those seven days sowed

the seeds for a lifelong involvement in clinical practice, spanning five continents, 12 general practices and 11 Universities. My 48 years as a practising clinician started in hospital medicine, became established in general practice and finished in addiction medicine. A common thread, expanding on the words of homelessness blogger, Laura Bianca-Pruett, was working with the last, the least, the lonely and the lost. Ironically, in terms of my future career prospects, my interview with Sir Edward had consigned me to the fourth of these categories. The abrupt termination of our cordial conversation had been precipitated by my politely declining his offer of the prestigious Hall Fellowship, linked to his Unit. Clearly, my decision to pursue a career in general practice was seen as a temporary mental aberration. Because of my academic success as a student, the expectation was for me to be in the vanguard of those thrusting towards that tall ladder. However, my elective in rural general practice had opened my eyes to the world beyond the hospital walls, following the "road less travelled." I learned that a pilot training scheme for general practice had just been established in Glasgow, and after discussion with the organisers and considerable soul-searching, I applied and attended an interview. I was awaiting the outcome of this interview when I received a letter from Professor Sir Edward McGirr, inviting me to discuss the Hall Fellowship, a much-coveted three-year appointment that facilitated a fast-track to consultant status. As I wandered along the lonely hospital corridor, leaving behind the flames of my burning boat, I began several excruciating days in limbo, awaiting the outcome of my other interview. The letter offering me a place on the training scheme launched my voyage into the world of general practice.

Before accompanying me on this journey, it might be useful to learn a little more about this world. The term "general practitioner" was first used in 1809, and its appearance disturbed the longstanding stability in the provision of medical care in Great Britain. Previously, the respective territories of the learned physician, the craftsman surgeon and the tradesman apothecary were well-demarcated and fiercely guarded. Only 20 years before the Medical Act of 1858, which established a common

course of training for all doctors, the following notice was displayed in the window of an apothecary's shop in Manchester:

> **Surgeon and Apothecary. Prescriptions and family medicines accurately compounded. Teeth extracted at one shilling each. Women attended in labour, two shillings and sixpence each. Patent medicines and perfumery. Best London pickles. Fish sauces. Bear's grease. Soda water. Ginger beer. Lemonade. Congreve's matches and Warren's blackening.**

Entrepreneurial and marketing skills were well established in the nineteenth century!

The profession of general practice developed through the 19th century and into the 20th, strengthened by the implementation of Lloyd George's National Insurance Act in 1911 and the introduction of the National Health Service (NHS) in 1948. In the early days of the NHS, general practice was at a low ebb. The Collings Report was published in 1950 – an intensive study of English general practice, conducted by an Australian GP. His 31-page report concluded: "The overall state of general practice is bad and still deteriorating." Since then, however, a remarkable transformation has occurred, but even in the 1960s general practice was still the poor cousin to hospital medicine.

There are many definitions of a general practitioner. I prefer this one: "A doctor who provides personal, primary, preventive and continuing care to individuals, families and a practice population."

Two fundamental concepts influence the daily work of GPs – whole person medicine and patient autonomy. Both depend on the quality of the patient-doctor relationship. This relationship can be rich in shared experiences, and both patient and doctor will have given much to it and can draw benefits from it – what Michael Balint, a psychiatrist who worked closely with GPs, termed the "mutual investment company."

On average, over a one-year period, GPs have contact with nearly 80%

of their patients – this rises to over 90% over five years. Such repeated and continuing contact with individuals provides unique opportunities to nurture and develop the patient-doctor relationship. This ties in with Balint's concept of the drug "doctor" – by far the most powerful and frequently used drug in general practice. However, as in prescribing any drug, practitioners must be aware of their own personal "pharmacology" – their strength, efficacy, side effects, interactions and the dangers of over-dosage.

To illustrate the scope of whole-person medicine, let me tell you about Derek, a patient of mine for many years. Derek is a portly, bearded, taciturn man who walks with a limp and a stick, the result of a childhood leg injury. Following a turbulent childless marriage and divorce, he remarried. His second wife, whom he calls Twinkle, has been widowed twice – both husbands died of heart attacks. Previously well, Derek has within the last few years sustained two heart attacks, forcing him to retire from teaching. This left him with moderately severe angina, which has not responded to a variety of different medications. Coronary angiography has revealed generalised disease, but no specific areas amenable to surgical treatment. His wife accompanies him on his visits to the surgery, joking about not letting him out of the house on his own. When he attends, he brings along examples of the exquisite miniature furniture which he now spends his time making, and he always enquires about the health and activities of my family. He feels angry, cheated and frustrated at his physical limitations. Conventional medicine has nothing left to offer him.

In his short story, *A Country Doctor*, Franz Kafka wrote: "To write prescriptions is easy, to understand people is hard." To understand Derek and Twinkle and what I might offer them as a GP, I need knowledge and skills related to anatomy, electro-physiology, psychology, pathology, cardiology, transactional analysis, surgery, pharmacology, orthopaedics, epidemiology, sociology and even woodwork and the history of furniture. This is the very essence of general practice –what has been described as a blend of science and humanity. Perhaps the most distinctive attribute of

the GP is a commitment to people, more than to a body of knowledge or a branch of technology. This is perfectly exemplified by the Māori proverb: "He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata!" (What is the most important thing in the world? It is people, it is people, it is people.)

GPs are the first medical "port of call" for patients, irrespective of their age, gender, ethnicity, socio-economic status, or the type of illness they have or believe they have. They deal with common diseases and problems, some self-limiting, others chronic, many initially presenting in early and undifferentiated forms. Although very few are serious in a life-threatening sense, many can cause much disability and great unhappiness. Robin Fraser, former Professor of General Practice at Leicester University, captured the challenge of the GP's task:

"The general practitioner, therefore, particularly needs to develop skills as a primary assessor of problems in a situation where multiple problems are often presented in a single consultation, where there are many symptoms but few clinical signs, and where there is frequently a complex mix of physical, social and psychological factors. In particular, he needs to develop the ability to be appropriately selective in history-taking, in performing physical examinations and in use of investigative facilities. He also needs to tailor his approach to suit the individual patient. By this means 90% of all illness presenting to the general practitioner is dealt with solely by him and his team."

This task requires doctors who are masters of the scientific and humanitarian aspects of medicine, because both the science and art of medicine play essential parts in the care of every patient. The challenge involves balancing their role as guide, philosopher and friend with that of medical adviser. This unique skill is epitomised in Maya Angelou's words: "People will forget what you said, people will forget what you did, but people will never forget how you made them feel." The consultation has been described as a "meeting between experts," the patient being the expert on his or her own life and experiences. Working in the front line of medical care, patients are often our best teachers. I have certainly learned many lessons from my patients. Being a doctor is a special

privilege. You have opportunities to be intimately involved in the lives of your patients, to enter their homes and share their thoughts, fears and aspirations. You can be present at births and at deaths, and all the events in between.

This memoir covers serendipity, perseverance, surprises and disappointments. It involves a diverse range of events, stories and characters – inspiring, amusing, quirky, poignant and instructive. I will make liberal use of quotations throughout, following the practice of my national bard and hero, Robert Burns: "I pick up favourite quotations, and store them in my mind as ready armour, offensive or defensive, amid this turbulent existence."