**Personal paper**

**The other end of the telephone**

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The General Medical Council advocates a broad experience in general professional training for doctors intending to be specialists and has indicated that a period in general practice would be beneficial. Trainee posts are usually available only to those planning a career in general practice. The Education Committee for General Practice, of the University of Newcastle upon Tyne, however, has recently made available a small number of trainee posts for doctors planning to remain in the hospital service. I was fortunate to spend six months of my two year paediatric rotation in general practice in the Northumberland market town of Hexham.

When the suggestion was first made that I should apply for such a post, I treated it with a great deal of caution. I feared members of a future interviewing panel would shake their heads over my curriculum vitae and ask me searching questions about why I had taken my foot off the ladder of career paediatrics. The panel was sure to follow the conventional view at my medical school that it was unhelpful, even detrimental, to supplement hospital training with experience in general practice. My exposure to three aspects of practice convinced me that this view was misguided. These were the decision of referral, the management of trivial problems, and the development of a rapport with my patients.

**Referral**

In an average week each partner in my practice would refer seven non-acute and two acute patients for care by other doctors. There was, therefore, no shortage of opportunity to sharpen my skills at this form of decision making, a process which was hardly mentioned at my medical school, and which in hospital practice was too often left to the last minute as a sign of clinical ignorance or defeat.

The most stressful of these decisions was the referral of an acute admission. My previous involvement had been as the duty houseman on the other end of the telephone, woken at 3am from much desired sleep, when I considered a request for admission from a general practitioner to be both a ‘fait accompli’ and a prime example of ‘passing the buck’.

The telephone call, I now realise, hides too well the minutes or hours of painful indecision that may have preceded it. It is not easy to weigh up the pros and cons such as degree and severity of illness or amount of family support, which are not measurable in simple units. For example, to what extent should the distance to the referral centre (22 miles for paediatric cases) influence whether illness of a certain severity be cared for at home? Or, how much should assessment of the patient’s insight into the nature and dangers of the illness influence me in postponing an admission? Alarming, I found that my equation involved some unwelcome and more subjective variables like intellectual curiosity, professional pride, how many patients there were still to see and, of course, fatigue.

I did not solve all the problems involved in referral, although I found that a scrap of paper listing items that I and the hospital could and could not offer, made difficult decisions easier. If this failed, discussion with the hospital doctor often helped. In any event, upon my return to hospital I would certainly never ask the general practitioner the patient’s hospital number or rectal temperature as the poor man may be standing in the one and only windswept coinbox on a council estate clutching his last 10 pence piece, and fighting off a stray Alsatian.

**The problem of trivia**

I saw about 120 patients each week in a surgery that was open to any of the 8000 residents on the practice list, and it was not surprising that much of the work involved seemingly trivial problems. At medical school the emphasis had been on the management of diseases with dynamic pathology, and patients that presented in hospital with minor illness were often discharged to the care of their general practitioner. I, therefore, felt inadequately prepared for this type...
of work. Special problems arose from the twin enemies of boredom and helplessness.

My initial boredom arose from a perceived lack of challenge in diagnosis and management. This soon changed. I discovered that trivial problems for the doctor did not necessarily seem so to the patient. My intellectual pride had let me believe that a patient with an ‘interesting’ disease, such as carcinoid syndrome, should feel worse than one with a ‘trivial’ disease, such as a cold. It did not take many surgeries to learn how rotten and depressed tonsillitis or otitis externa can make someone feel. Not only did many of my patients with ‘trivial’ disease feel awful, but they also thought they had something very serious. It was a source of quiet satisfaction to reassure all these unhappy people. Two patients thought that their viral upper respiratory infections were in fact AIDS and leukaemia and were very relieved by our discussion.

Another challenge was to maintain my sharpness for diagnosis, surgery after surgery, spot after spot, cough after cough. I tried to develop a set of clinical alarm bells that would ring even if coffee was only 10 minutes away. Of course, we all use these in hospital medicine but I never found them more helpful than in practice. The bells often coaxed me into action in the warm surgery where a soporific mood was so easily encouraged by the plush leather upholstery and homely matching of carpets, curtains, and wallpaper.

Another helpful approach was to ask about each patient, ‘Why has he come to see me?’ Failure to ask this allowed me to miss recognising a prolonged grief reaction presenting as persistent frontal headaches.

I experienced helplessness frequently when dealing with the commoner complaints of practice because I felt I had insufficient to offer by way of explanation or treatment. Too often I tried to hide this by replying in a stereotyped manner: ‘Oh yes, very red, Mr. N…… likely to be a virus though, very common in Hexham at this time of year …… no point in antibiotics, it doesn’t look that sort ……..’

Curiously, I did find that most of Hexham still recognises the word ‘virus’ as a code for something harmless despite the advent of AIDS and oncogenes. But they also recognised my lack of sincerity and many of these patients turned to my trainer for a more satisfying response. A kind and honest explanation of my ignorance about even common diseases was, I soon discovered, the route to success.

Many of the common illnesses of practice naturally are paediatric and I had the opportunity of seeing many conditions that rarely if ever reach hospital. These included my first sighting of measles in two years of paediatrics, chilblains, glandular fever, and hand, foot, and mouth disease. Seeing so many cases of diseases such as rubella and glue ear gave me a clear picture of the range of severity, the various forms of presentation, and the vast potential for epidemiological research in practice.

Getting to know the patients

Furthering my insight into the intimate lives and background of some of my patients was a rewarding part of my attachment. What I managed to learn in six months was small in comparison with the knowledge of any of the partners who had each worked at the surgery for between 18 and 25 years. I should be surprised if anyone in the town, except perhaps the receptionists, held their ears to the ground quite so closely as did my trainers! Any paediatrician will forget this at his peril. If one needs to know more of Hexham’s complicated genealogy, which children are most endangered by abuse or even who beats their wife and how often, one need go no further than my trainers.

To my surprise I did get to know some families very well in six months. One such family lived in the poorer east end of Hexham. On only my second day in surgery Mrs J brought her 3 year old daughter, Emma, along complaining that the girl had developed puffy eyes over the previous week. Despite exhortations on the vocational training course that general practice was not about discovering clinical ‘gems’ to be passed on to the master jeweller in the city, I found her to have gross proteinuria and dutifully sent her to hospital with a provisional, and soon substantiated, diagnosis of nephrotic syndrome. I soon found out that such a case should be diagnosed once in every 20 general practitioner years and so felt naturally very proud that I had unearthed a diamond. Fortunately for myself, I did not spend the remaining six months searching for another, although several others came my way. There were more precious stones to be found in other forms.

After some two weeks in hospital Emma’s urine was pronounced clear after a course of steroid treatment and she was released home. As was usual in the practice, I visited the home after discharge and except for Emma’s occasional steroid induced extroversion and a sleep reversal pattern, all seemed well in the household.

At this stage I might have understood her medical condition but I turned out to understand very little of what was happening in the family. My next contact with Mrs J and Emma came when they turned up at the surgery clutching a low salt diet.
Richards

sheet and complaining that all the foods turned out to be too dry. Although I did not realise at the time, the long list of the foods that her daughter was forbidden had dulled her mind of ideas for attractive juicy food. Rather misguidedly I thought that my suggestion of low salt white sauce would sort out the problem. This was greeted by Mrs J with a blank stare as she had never made white sauce. Nor could Mrs J’s mother, who was summoned from the waiting room to help us out of this impasse. We all eventually settled for a simple gravy from vegetable water, flour, and browning!

Two weeks later, Mrs J returned to my surgery in tears. To my surprise she had left her husband, driven out, she said, by threats of beatings and some Scrooge like financial dealing by her husband, who preferred to drink his earnings rather than feed and clothe his two children. This left Mrs J poorer still, isolated from her shared friends, and very depressed about looking after her children in her mother’s small spare room in her council house. Emma’s recent illness did not help her peace of mind. As she sat there crying in my surgery I realised how little I knew of her lifestyle and the problems that brought about and had been caused by her separation. Over subsequent weeks Mrs J returned on numerous occasions to my surgery, often with the excuse of a problem with Emma or her brother. These visits allowed me to sketch in some of the background information especially concerning Mrs J’s family upbringing and Mr J’s drinking habits, which had contributed to the breakup. Getting to know this family so well certainly made me wonder how it was possible to make judgments about the future of problem families with less information. Could an estranged hospital doctor in the unsettling ward atmosphere have hoped to gain a similar degree of insight as I had achieved in my patient’s natural home? Such an experience left me in no doubt about the important part that the health visitor and general practitioner play in social paediatrics.

Coda

I thoroughly enjoyed my six months as a general practitioner trainee. It is a reflection on the limited nature of my medical training that so much of the experience was new. I no longer feel apprehensive about discussing this post in front of my next interview panel. A sceptical member may expect me to justify that most of the time was spent with non-paediatric cases. I would explain that in addition to helping me with the specific areas described above, it has provided inside experience of a system in which most paediatric consultations take place and upon which the smooth running of hospital care depends.

I hope that this explanation will not be necessary when in future it is looked upon as an essential, not additional, preparation for a career in hospital paediatrics.

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Arch Dis Child 1989 64: 886-888
doi: 10.1136/adc.64.6.886

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