The last three patients: general practice (Patient One)

BY JONATHAN REES

Professor Jonathan Rees is an Emeritus Professor of Dermatology at the University of Edinburgh (2020). He held the Grant Chair of Dermatology in Edinburgh from 2000 to 2020, and before that the Chair of Dermatology in Newcastle from 1992 to 1999. He trained in dermatology and clinical science in Newcastle, Vienna and Strasbourg. Academically, he tends to be a serial monomaniac, although much of his work has focused on skin cancer and the effects of ultraviolet radiation on skin. In the first of a three-part series, Prof Rees reflects on his last three patients at different stages of his medical practice.

When I was a medical registrar, I did GP locums for a single-handed female GP in Newcastle. Doing them was great fun, and the money — she insisted on British Medical Association (BMA rates) — was always welcome. Nowadays, without specific training in general practice, you can't act as a locum as I did then. This is probably for the best but, as ever, regulations always come with externalities, one of which is sometimes a reduction in overall job satisfaction.

I worked as a locum over a three-year period, usually for one week at a time, once or twice a year, covering some of the GP's annual leave. Weekdays were made up of a morning surgery (8:30am to 10:30am or later), followed by house-calls through lunchtime to early afternoon, and then an evening surgery from 4:30pm to around 6:30pm. I also ran a short Saturday morning surgery. Within the working day I could usually nip home for an hour or so.

From 7pm until the following morning, the Doctors Deputising Service (DDS) took over for emergency calls. They also covered the weekends. The DDS employed other GPs or full-time freelancers. Junior hospital doctors often referred to the DDS as the Dangerous Doctor Service. Whether this moniker was deserved, I cannot say, but seeing patients you don't know in unfamiliar surroundings is often tricky. Read on.

Normally, the GP would cover the nights herself, effectively being on call 24 hours per day, week in, week out. Before she took leave, she used to proactively manage her patients, letting some of her surgery 'specials' or 'regulars' know she would be away, and therefore they might be better served by waiting for her to return.

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Because she normally did her own night-calls, she was aware of how a small group of patients might request night visits that might be judged to be unnecessary. I think the fee the DDS charged to her was dependent on how often a visit was requested, so, as far as was reasonable, she tried to ensure her patients knew that when she was away, they would only get a visit from a 'stranger' — home night-time call-outs should be for real emergencies. I got the strong impression that her patients were very fond of her, and she of them. Without exception, they were always very welcoming to me, and I loved the work. Yes, I got paid, but it was fun medicine, and offered a freedom that you didn't feel in hospital medicine as a junior (or senior) doctor.

The last occasion I undertook the locum was eventful. I knew that this was going to be the last occasion, as that summer I was moving on from internal medicine to start training in dermatology — leaving for Vienna in early August. A request for a house-call, from a 40-year-old man with a headache, came in just as the Friday evening surgery was finishing, a short while after 6:30pm. My penultimate day. I had been hoping to get off sharpish, knowing I would be doing the Saturday morning surgery, but contractually I was covering to 7pm, so my plan was to call at the patient's house on the way home.

I took his clinical paper notes with me. There was virtually nothing in them, a fact that doctors recognise as a salient observation. He lived, as did most of the surgery's patients, on a very respectable council estate that literally encircled the surgery. I could have walked, but chose to drive, knowing that since I had locked up the surgery, I could go straight home afterwards.

When I got to his house, his wife was standing outside, waiting for me. She was most apologetic, informing me that her husband was not at home, but had slipped out to take his dog for a walk. I silently wondered why if this was the case, he couldn't have taken the dog with him to the surgery, saving me a trip. No matter. Grumbling about patient behaviour is not unnatural, but is often the parent of emotions that can cloud clinical judgement. There lie dragons.

The patient's wife ran to the local park to find her husband, who, in tow with her and the dog, came running at a fair pace back to the house a few minutes later. The story was of a headache on one side of his head, posterior to the temple, that had started a few hours earlier. The headache was not severe, he told me, and he felt well; he didn't think he had flu. His concern was simply

because he didn't normally get headaches. There was nothing else remarkable about his history; he was not on any medication, and had no preexisting complaints or diseases beyond the occasional cold. Nor did the actual headache provide any diagnostic clues. On clinical examination, he was apyrexial, with a normal pulse and blood pressure, and a thorough neuro exam (as in that performed by somebody who had recently done a neuro job) was normal. No neck stiffness or photophobia and the fundi were visualised and clear. The best I could do was wonder about a hint of erythema on his tympanic membrane on the side of the headache, but there was no local tenderness there. I worried I was making the signs fit the story.

I told him I couldn't find a good explanation for his headache, and that my clinical examination of him was essentially normal. There was a remote possibility that he had a middle ear infection, although I said that since he had no history of previous ear infections, this seemed unlikely. I opted to give him some amoxycillin (from my bag) and said that whilst night-time cover would be provided by the DDS, I would be holding a surgery on the Saturday morning in just over 12 hours. Should he not feel right, he should pop in to see me, or I could visit him again. He and his wife thanked me for coming round, I went home and, as far as I knew, that was the end of the story of my penultimate day as a locum GP. He did not come to my Saturday morning surgery.

Several weeks later, when I was back doing internal medicine and on-call for urgent GP referrals, the same GP phoned me up about another of her patients who she thought merited hospital assessment. This was easily sorted, and I then asked her about some of the patients of hers I had seen when I was her locum. There was one in particular, with abdominal pain, whom I had sent into hospital, and I wanted to know what had happened to him. She then told me that the patient had meningitis. There was a moment of confusion: we were not talking about the same patient.

The story of the man with the headache was as follows. I had seen him just before 7pm, apyrexial, fully conscious, with a normal pulse and blood pressure, and no neuro signs. By 8pm his headache was much more severe, and his wife put a call into the DDS who saw him before 9pm, but could not find anything abnormal. By 10:30pm he was barely conscious, and his wife called the DDS who were going to be delayed. Soon after, she dialled 999. He was admitted and diagnosed and treated for bacterial meningitis. The GP told me he had made a prompt and complete recovery.

That was the last patient I ever saw in general practice.

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