The last three patients: dermatology (patient three)

BY JONATHAN REES

For the third and final reflection in this series, Professor Jonathan Rees recounts his experience of a patient with cancer who was failed by the NHS, and how their inadequate treatment illuminates some issues which are at the forefront of our national health service.

He was nearer 70 than 60, and not from one of Edinburgh's more salubrious neighbourhoods. He sat on the examination couch unsure what to do next. His right trouser leg was rolled up, exposing a soiled bandage crusted with blood that had clearly been there for more than a few days. He nodded as I walked into the room, and I introduced myself with a shake of his hand. This was pre-COVID.

I knew his name because that was typed on the clinic list alongside the code that said he was a new patient, but not much else – not much else because his clinical folder contained sticky labels giving his name, address, date of birth and health care number only. That was it. As has become increasingly the norm in the clinic, you ask the patient if they know why they are there.

He had phoned the hospital four days earlier, he said, and that he was very grateful he had been given an appointment to see me. He thanked me as though I was his saviour. If true, I didn't know from what or from whom. If he was a new patient, he would have seen his GP and there should be a letter from them in his notes. But no, he hadn't seen his GP for over a year. Had I seen him before? No, he confirmed, but he had seen another doctor in the very same department about 18 months previously. I enquired further.

He said he had something on his leg, at the site of the distinctly un-fresh bandage, and that they had done something to it. It had now started to bleed spontaneously. He had phoned up on several occasions, left messages and, at least once, spoken to somebody who said they would check what had happened and get back to him. 'Get back to you' is often an intention rather than an action in the NHS, so I was not surprised when he said that he had heard nothing back. His leg was now bleeding and staining his trousers and bed clothes, hence the bandage. He thought that whatever it had been had come back.

Finally, four days before this appointment day, after he relayed his story one more time over the phone, he had been given this appointment. He again told me again how grateful he was to me for seeing him. And no, he didn't know what diagnosis had been made in the past. I asked him had he received any letters from the hospital? No. Could he remember the name of any of the doctors he had seen? Sadly not. Had he been given an appointment card with a consultant's name? No.

There was a time when nursing and medicine were complementary professions. At one time, the assistant who ushered him into the clinic room would have removed the bandage from his leg. In my clinical practice, those days ended long ago. I asked him if he would unwrap the bandage while I went in search of our admin staff to see if they knew more than me about why he was here.

He had been seen before, just as he had said, around 18 months earlier. He had seen an 'external provider', one of a group of doctors employed via commercial agencies who are contracted to cope with all the patients that the regular staff employed by the hospital are unable to see. That demand exceeds supply is the one feature of the NHS that all agree on, whatever their politics. It outlives all reorganisations. Most of these external provider doctors travel up for weekends, staying in a hotel for one or more nights, and then fly back home. They get paid more than the local doctors (per clinic) and the agency takes a substantial arrangement fee in addition. This has been the norm for over 10 years, and of course makes little clinical or financial sense — except if the name of the game is to be able to shape waiting lists with electoral or political cycles, turning the tap on and off – usually more off, than on.

The doctors who undertake this weekend work are a mixed bunch. Most of them are very good, but of course they don't normally work in Scotland, and medicine varies across the UK and Europe and even between regions within one country. It is not so much the medicine that is very different, but the way that different components of care fit together organisationally that are not constant. This hints at one fault line.

That the external doctors are more than just competent is important for another reason: the clinic lists of the visiting doctors are much busier than those of the local doctors and are full of new patients rather than patients brought back for review. The NHS and the government consider review appointments as wasteful, and that is why all the targets relate to 'new' patients. It's a numbers game: stack them high, don't let the patients sit down for too long, and process them – meet those government targets and move in phase with the next election cycle. Consequently, the external provider doctors are being asked to provide episodic care under time pressure; speed dating rather than maintaining a relationship. For most of the time, nobody who actually works in Edinburgh knows what is going on with the patient, but the patients do live in Edinburgh.

Old timers like me know that one of the reasons why review appointments are necessary is that they are a security net, a back-up system. In modern business parlance, they add resilience. Like stocks of PPE. In the case of my man, a return appointment would have provided the opportunity to tell him what the hell was going on and to ensure that all that had been planned had been carried out. There is supposed to be a beginning, a middle and an end. There wasn't.

An earlier letter from an external doctor was found. It was a well-written summary of the consultation. The patient had a lesion on his leg that was thought clinically to be pre-malignant. The letter stated that if a diagnostic biopsy confirmed this

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clinical diagnosis (it did) then the patient would require definitive treatment, most likely surgical. The problem was that in this informal episodic model, the original physician was not there to act on the result, nor to observe that the definitive surgical treatment had not taken place because review appointments are invisible in terms of targets. They are wasteful.

Even before returning to the clinic room, without sight of anything but the blood-stained bandage, I knew what was going on. His pre-malignant lesion had, over the period of ‘wasteful’ time, transformed into full-blown cancer. He now had a squamous cell carcinoma. His mortality risk had gone from effectively zero to maybe 5%.

I went back to the clinic room, apologised, explained what had gone on and what needed to happen now, and apologised again. The patient picked up on my mixture of frustration, shame and anger, and it embarrasses me to admit that I had somehow allowed him, mistakenly, to imagine that my emotions were a response to something he had said or done. I apologised again. And then he did say something that fired my anger. I cannot remember the whole sentence but a phrase within it stuck: ‘not for the likes of me’. His response to the gross inadequacy of his care was that it was all people like him could expect.

He was not literally the last patient in dermatology I saw, but his story was the one that told me I had to get out. When a pilot or an airline engineer says that an aircraft is safe to fly there is an unspoken bond between passengers and those who dispense a professional judgement. But this promise is also made by one human to another human. I call it the handshake test, which is why I always shook hands when I introduced myself to patients. This judgement that is both professional and personal has to be compartmentalised away from the likes of sales and marketing, the share price — and government targets or propaganda. This is no longer true of the NHS. The NHS is no longer a clinically-led organisation, rather, it is a vehicle for ensuring one political gang or another gains ascendancy over the other at the next election. It is not so much about money, as about control. True, if doctors went down with the plane, in this metaphor, there would be a much better alignment of incentives. Doctors might be yet more awkward. Better still, we might think about where we seat the politicians and their NHS commissars.

Most doctors keep a shortlist of other doctors who they think of as exceptional. These are the ones they would visit themselves or recommend to family. If I had to rank my private shortlist, I know who would come number one. She is not a dermatologist, but a physician of a different sort, and she works far away from Edinburgh. She has been as loyal and tolerant of the NHS as anybody I know, much more than me. Yet she retired before me, and her reasoning and justification were as insightful and practical as her medical abilities. Simply put, she could no longer admit her patients and feel able to reassure them that the care they would receive would be safe. It’s the handshake test.

I don’t shake hands with patients anymore.

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