London 2012 was home to the thirtieth summer Olympic Games. One July evening like millions of others all over the globe I watched the spectacular opening ceremony. At this ceremony, the hosting country showcases what it considers to be its pride and joy – a gem to show off to the whole planet. At a certain point during that glitzy evening, a bevy of beds appeared in the stadium. Pyjama-clad children jumped on them while “nurses” and “doctors” danced cheerily around. It portrayed Great Ormond Street Hospital and was a tribute to the NHS – the National Health Service.

The NHS is over 60 years old. It was established after the Second World War. The founding principles were good – universal health care for all free at the point of delivery from the cradle to the grave. The idea was that as the health of the population improved, there would be less need of the NHS. This has not been the case. With developing new drugs and technology, the increasing longevity of a healthier and not so healthy masses and the labelling of new disease – pseudo and real – the NHS is at its knees. More and more is being asked of it with fewer and fewer resources. This is the scenario for many health care systems all over the world.

I work for the NHS - in London precisely and to be even more exact – in Lambeth. I am a General Practitioner and I deliver primary care. I do not do this alone but in a team. The standard primary care team consists of GPs, practice nurses, practice manager, administrative staff, health visitors, and district nurses. Members of the team regularly meet together. Each one of us takes the lead depending on the matter at hand. It might be the practice nurse on one occasion, the practice manager on another or the GP as we all have different though complementary skills. Primary and community care services are usually the first level of contact between people and the NHS. GPS now have a major commissioning role. Today we must balance quality of care and patient experience with efficiency and productivity targets.¹

The Alma Alta Declaration states

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.²

The King’s Fund is an independent charity which works to improve health and health care in England. It helps to shape policy and practice through research analysis. The King’s Fund commissioned ten research projects on the following dimensions of primary care:
The Role of Primary Care. Dr Mabel Aghadiuno

- the management of acute illness
- the quality of diagnosis and referral
- prescribing and prescriptions management
- the management of people with long-term conditions, including mental health problems
- health promotion and ill-health prevention
- access to care
- continuity of care – or how well general practice is integrated into the rest of the health care system
- patient engagement and involvement
- end-of-life care
- tackling inequalities in general practice.

In addition, four discussion papers were commissioned on the following areas:

- the quality of the therapeutic relationship
- improving the quality of commissioning services from general practices
- the quality of maternity care in general practice
- clinical leadership.³

These areas cover the scope of my working day. I am a General Practitioner. The General Practitioner (also known as family physician or primary care physician in other countries) has evolved differently in various parts of the world. An important role of the General Practitioner is to act as gatekeeper – determining what should be referred on to secondary care. As a GP I determine – together with the patient – what should be referred to hospital. We are expected to manage patients using evidence-based criteria and refer appropriately with referral guidelines. I am expected to be autonomous and manage most acute and chronic disease. Only a small percentage of the patients that I see will be referred to hospital and once the patient is seen there, he or she will be referred back to me to continue his care. I am the link person who holds the main medical records of the patient in one central space.

Lambeth where I work is in South London – a microcosm of the world. It is the ninth most socially deprived region in the country with a population of almost 300,000. There are about 52 general practices with 37% of the population belonging to Black and ethnic minority groups. It is the youngest borough in the UK – more than 50% of people are aged 20-44. 300 languages are spoken in Greater London and almost 100 different languages are present in every London borough.

The Postgraduate Medical Education department has produced a DVD which is a valuable resource for any GP working in a multilingual city. It is called Doing the Lambeth Talk. 232
GP consultations were filmed for the project. The DVD features consultations with English, Italian, Somali, Gambian and Colombian patients all with differing ideas and expectations concerning the GP. The discourse of the consultations was transcribed and analysed. The research shows that patients who speak local London or standard English – whatever the ethnic background – tend to present their symptoms and themselves in routine ways:

- they talk about their symptoms
- they give a context in which these symptoms occur
- they indicate their perspective of the problem
- they sometimes talk about self-treatment

Instead patients not born in the UK bring to the consultation patterns of how they would talk to a doctor. They may have diverse styles of communication, differ in how direct or explicit they are, how far they agree or disagree with the doctor and may not present their case in the package given above. They may present a collection of feelings rather than symptoms.

Many ethnic minority patients may have experiences of racism, of not being understood or not judged as sufficiently worthy and they may bring this into the consultation. They may feel they have to exaggerate their symptoms to be taken seriously.

In countries where hierarchical relationships are more prominent, the patient may give little information to the doctor and wait for the GP to decide what the problem is. A patient from Somalia may be very anxious about her daughter having what the GP thinks is simply viral diarrhoea when from her experience, diarrhoea can be fatal in her own country.4

I shall give you some statistics to give you a taste of my practice population. In 2008, the life expectancy of males in England stood at 77.9 years while in Lambeth it was 75.7 years. Studies have shown the more socially deprived an area, the greater the presence of chronic disease – Lambeth has a high prevalence of chronic disease. It also has the highest prevalence of HIV in England – 13.3% per 1000 population compared to 5 per 1000 in London and 0.7 per 1000 in the North-East of England. We diagnose at least one new case of diabetes a day and even more of prediabetes.

Thirty years ago, Julian Tudor Hart wrote about the Inverse Care Law. Unfortunately it still applies today. The Law states that those most likely to need medical care are the least likely to receive it. Conversely, those with the least need are accustomed to use the health services more.5 Inverse laws are found everywhere in society and they are generated fundamentally by income inequalities. People living in areas of high socio-economic deprivation suffer because of

- Poor quality services
- Difficulty accessing or ignorance about services
- Multiple external disadvantages.6
This is what many GPs experience in inner-city practices.

Our patients are not disembodied limbs or hearts but people who live within society with all its challenges, joys and adversity. A typical day I will have 15 face-to-face patient contacts in the morning and 15 in the evening. Then there are telephone consultations, phone calls with hospital consultants, social workers, hospital letters to write and read, lab reports to decipher and home visits. I have to examine the newborn babe and help the dying.

I kept a diary of one the patients I saw at one Monday morning surgery:

- Calcaneal spur, exacerbation of asthma and hearing problem.
- Miscarriage at 6 weeks. Past history of abortion.
- Homeless man with epilepsy; staying with friend. Diet unhealthy and difficult to take medication at regular time.
- Woman who went to hospital with vague symptoms of sweating and dyspepsia. Raised GGT and CRP.
- Woman with gender identity disorder who is going through process of becoming a man.
- Man with palpitations.
- Rastafarian with alopecia; mechanical back pain and problems at work.
- Woman with dyspepsia.
- Woman with gross obesity, aged 50 trying to become pregnant. Difficult to explain to her how obesity affects pregnancy.
- Man went to holiday in USA – told he had flu but when he got back here found to have bacterial endocarditis.
- Woman with headache.
- Woman with depression.
- Woman with anterior knee pain for 3 months.
- Man who was unhappy about statin.
- Type 2 diabetic on insulin who has two children with Sickle Cell Disease – problems of managing her own illness and those of her children.
- 80-year old man with Type 2 diabetes and varicose veins.

In primary care I believe I have to use resources wisely and responsibly. Just because the NHS is free, it does not mean that I can use taxpayers’ money as I or the patient wishes. For example I worked for three years in a tough Liverpool inner-city practice. The list size was almost double that of the average GP and the work load was heavy. The GP I worked for would give antibiotics for sore throats and colds without seeing patients. He took short cuts. At the end of surgery the receptionist would come with a box full of patient records and attached sticky notes with the words “sore throat, no allergies”. It was quite obvious – the patients wanted antibiotics. I instead refused to give them and insisted that if the patients felt they were ill enough to need antibiotics I would expect them to come in to be examined. At first the patients did not want to see me. Gradually they came in – I was prepared to see them...
in my own time after surgery – and they saw that I examined them thoroughly and cared for them. They were able to accept my decision not to give antibiotics for what were essentially viral infections.

I shall share some other cases with you.

Case One

Mr O came to see me one day earlier this year. We have a paperless working environment so all the records are computerised. I quickly checked his notes and saw that he had been to the surgery on different occasions. He had also seen different GPs because of various circumstances so there was a lack of continuity of care. He told me that he had pins and needles in both hands. He was a capable man who had done a responsible job until the previous 12 months. He came to see me because the Benefits Office had declared he was not fit for work and needed certification from the GP to state this. It would have been easy to just give him the medical certificate and continue with my busy surgery – after all, he had seen other colleagues. However the question I began to ask myself were

Why should this man be unable to work because of paraesthesia?

He could not articulate the story of his illness in the straightforward way to which I was accustomed. I realised I had to translate his words and not rely on his giving me symptoms I considered meaningful. I noted how he had shuffled into the surgery - inconsistent with the diagnosis of “carpal tunnel syndrome”.

I did a full neurological examination and concluded he might have some sort of peripheral neuropathy. The outcome: he had an MRI scan and impingement of the cervical cord was discovered. He later had an operation and now his gait has improved and the power of his hands. It showed me yet again the importance of understanding a patients’ illness narratives from their cultural perspective. His was a stoic culture where adversity is accepted. He did not complain and was very accepting. He would never dispute a doctor’s opinion. Grateful Mr O now considers that I have saved his life!

Case Two

I shall call this patient Mr Smith. Again it was a busy surgery and Mr Smith came to see me complaining of a minor illness. The symptoms were mild and we decided on conservative management. He was about to go when I started to observe him. I realised we had spoken but my history taking had been automatic. I had not really looked at him as a person. I looked at his hands and saw that they were very large. I looked at his face and it looked slightly dysmorphic. I then asked him something strange. I asked if his hands had always been big but he was quite perplexed. I asked if he had noticed a change in the size of his head. He looked at me oddly. I gave him a form for a blood test and suggested he do it as soon as possible. Shortly afterwards I left the surgery and was posted elsewhere.

About three months ago, one of the GPs I used to work three years ago left a message on my voicemail. He said that one of the patients wished to speak to me and he left the patient’s
number. I phoned the patient – it was Mr Smith. He was profusely grateful. He reminded me that I had given him a form for a blood test – which he had not bothered to do – but this proved vital two years later. He had gone to see his GP with vague symptoms and the GP was unclear about the nature of the problem. Mr Smith remembered that I had wanted him to have a blood test. He asked the GP look at his computer records and to arrange the investigation. The blood test was ordered and the result confirmed my original suspicion – acromegaly due to raised growth hormone levels. He was found to have a pituitary tumour and this was resected nasally. This taught me a lesson – personalised care above all means looking at your patient, observing and asking. It means never being ungenerous in time, care and attention.

Case three

Kingston, a Rastafarian man came to see me one day. He wore a Rasta cap and sported long dreadlocks. He was upset because he had alopecia. The alopecia happened to be stress-induced following a road traffic accident. I asked if I could examine his head. He was reluctant to take off his cap, because he was deeply ashamed. I looked at his head. He had lost some of the locks at the front of the head and there was a large patch of alopecia at the occipital region. He opened a plastic bag containing the locks which had fallen off. I then remembered hearing how the singer Bob Marley had been reluctant to have chemotherapy for fear of losing his dreadlocks. Kingston explained to me that his dreadlocks “were his identity”. He had been growing them since he was five years old. Alopecia for him was not just a matter of his appearance but it tied in deeply with his essence. In understanding what alopecia meant for him, I was in a better position to manage his case. Was referral to the dermatologists a good use of public funds given they might not be able to do much to help him? I think it was. At the least it showed I took him seriously and understood his pain.

I started off this talk with the Olympic opening ceremony and its tribute to the NHS. However the NHS is going through its difficulties. There is never enough money to go round, the drugs budget continues to rise and clinical care becomes ever more complex. In primary care today the government demands that we meet targets, give a high standard of care with dwindling resources. On its website The Department of Health (DH) states how it “helps people to live better for longer. It leads, shapes and funds health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.”

Without compassion we cannot function effectively as health professionals. Earlier this year, Robert Francis published his report on the failings of the mid-Staffordshire NHS hospital trust to deliver compassionate care. The contents of the report are still being digested but it has had and will continue to have implications for the way that nursing and medical staff are trained and practice. It demands a culture shift in the delivery of health care.

In a thought-provoking article on society’s perception of doctors, Jain and Cassel refer to the British economist, Julian le Grand, who suggests public policy perceives human beings as knights, knaves or pawns. The authors infer if doctors are knights, the stewardship of the
health system is in safe hands. These doctors “deploy resources wisely and look beyond their narrow, individual and specialty interests to protect the system as a whole”. If doctors are perceived as knaves, they put themselves first and patients second. These doctors must be “driven by rewards and incentives to motivate them to do what is right by their patients” and research is “driven by self-glorification and narcissism”. If doctors are perceived as pawns “the role of health policy is to guide and regulate his or her every behaviour, because he or she lacks individual agency and judgement to reliably do what is right”. Policy makers and regulators are the ones who decide clinical priorities.

Perhaps the invitation for us today amid the real challenges facing primary, secondary and tertiary care is to be doctors who are knights. In the middle ages, knights lived by a chivalric code. They defended the weak and helpless. They protected those who could not protect themselves. They were strong, noble, selfless and generous. At today’s congress globalisation, sustainability and personalised care are presented as the challenges - and there are many - we face today in medicine. I see compassion as the pivot which helps us deliver sustainable personalised care in an ever increasing globalised environment. Which are we - knights, knaves or pawns? The doctor as the compassionate knight certainly appeals to me.

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