

Short Communication

Reflections on a career in general practice: do older General Practitioners behave differently?

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Introduction

As a General Practitioner (GP) and Undergraduate Teacher for the past 22 years, I want to muse and reflect on my career with a view to considering my lifetime of professional learning. This essay is my attempt to reach some sort of conclusion, and I hope that I can make this work thought-provoking - in this respect I hope that my credentials as an author of other reflective pieces will stand me in good stead.

I have previously written about the role of honour, decency and professionalism as enshrined in the German-Jewish concept of a 'mensch', and I have tried to practise medicine by this code. [1] I have tried to care for my patients at all times, the subject of another paper. [2] I have tried to learn from previous experiences and to collate a historical perspective, the subject of a third paper. [3] This latest article seeks to build on these previous pieces from my present vantage point.

I recognise that I have the potential to be an 'old git' and that I run the risk of becoming so battered by my length of service that I might become entrenched in my world-view about UK primary care. Maybe my 'lack of youth' has meant that my opinions matter less to others and all they see is 'a dinosaur stuck in old ways'. Well if this is the case, this dinosaur can still 'roar' and have utility, and this piece may prove relevant, and hopefully show that older GPs still have a lot of inherent value.

My career so far

I became a half-time GP in a deprived area of Cardiff, Wales and in parallel with this a Teacher at Cardiff University in 1992. There have been continual changes within primary care during my career and I'm not going to discuss them all. However one illustration of the variation from the start of my career to my present position is the management of hypertension; in 1992 patients were referred to the tail-end of 'hypertension clinics' provided by secondary care whereas in 2015 most GPs surely provide multiple cardiovascular risk management themselves. Clearly General Practice is now considered a worthy bedfellow to 'proper medicine'.

To this could be added changes in psychiatric care, the concept of 'hospital in the community', the list of guidelines on care … and so many others. One of the original intentions of the National Health Service (NHS) was that, as the population became healthier, so the need for the NHS would lessen; however, Aneurin Bevan himself recognised 'We shall never have all we need… expectations will always exceed capacity. The service… must always appear inadequate'. [4] So there we are then, inadequacy has been the order of the day since 1948, and is likely to remain so. GPs as busy professionals will always be a part of that inadequacy, and my experience of my career so far is that there has been a lot of inadequacy on my part.

When I first qualified, there was a view that GPs were busy people and you shouldn't take up the (busy) doctor's time, a view described in a then famous book by Claire Rayner, 'Everything your doctor would tell you if he had the time'. [5] This concept almost seems farcical from the contemporary perspective of long working days and all the other aspects of our work which renders us so busy now, a view so brilliantly reported on just as this article was being prepared. [6]

However, the unchanging and enjoyable part of my GP career has been that GPs still provide comprehensive, continuing care to all patients and integrate physical, psychological and social aspects of patients and their illnesses. In my relish for my GP role I mirror the views of the subject of the most recent piece who clearly enjoys the GP role. [6] Further, this view is shared by the authors of two recent pieces written from the two ends of the GP career perspective – viz a now retired BMJ columnist and a Pulse blogger. [7,8]

Nonetheless, in parallel with this aspect of stability, a further feature of my 22 years' service is that I have worked through a constant series of NHS service changes, which at times feels like a form of perpetual Maoist revolution. If I were overly cynical, one of the purposes of this constant change has been to keep GPs (the 'workers') in a constant state of heightened awareness, fear and anxiety. There are potentially well known risks of long GP careers in the form of burnout and compassion fatigue. [9,10] It is important that all older doctors should strive to prevent this for themselves, and hopefully this piece may influence other 'oldies' to keep seeing the positives in the GP role.

On a personal level, at any time if I become too cynical, I always recollect a great truth from my professional youth. I was taught that the patient is the person in front of you, a point further refined by a maxim from a talk by David Haslam (a former President of the Royal College of General Practitioners, and thus a more eminent GP than I will ever be) that 'patients and the public overlap, but they are not the same'. The notion of striving to be a good person in its widest sense has brought me to the state of primarily 'doing good' for the patient in the consulting room, which may place me at odds with those who consider more abstract concepts of the 'wider good' in public health terms, and they may see me as not 'behaving' in terms of considering medicine from population-based perspectives.

Prevention now the thing

Talking of public health…. Surely no GP can fail to notice the plethora of interim outcomes for most diseases, and that our pay is dependent on meeting these outcomes in the form of the Quality Outcomes Framework. The topic of the value of QOF is beyond the remit of this piece, but there are views that GPs

have been partially reduced to form-fillers as a consequence of QOF; however I do intend to discuss these interim outcomes, and the role of screening, health and paradigms of prevention.

The fundamental principle is that prevention is better than cure, and that it is incumbent on us to prevent illness, especially if there are low side-effects from so doing. When I qualified the main discussion was on the role of medication in treating mild hypertension, with a study showing that some strokes were prevented, even though a third of patients experienced side effects. [11] At the time of writing (although the furore has died down a little), an equivalent discussion is taking place around the role of statins with those who have 10% risk of developing heart disease, which is an interesting issue considering my own risk as a 56 year old male. [12]

Overall, this is a new version of the seemingly perennial ongoing controversies in medicine, and patients will always be slightly perplexed by the plethora of information, and that doctors cannot agree appropriate definitive interpretations of the available data. I want to bring in a further principle here - I am getting older myself and as such I am likely to be faced with these decisions as a patient myself soon. I wonder if, in parallel to trying to do the best for my patients, I am unconsciously bringing a little of myself into the considerations and ensuing discussions with patients about the pros and cons about prevention for them.

Quality

This brings us to quality issues, and whether or not GPs are providing good quality care, an issue which has been in the news throughout my career. QOF scores can tell us a lot about ourselves (and our finances) but do they measure 'quality', as ill-defined in a cult literary classic, 'Zen and the Art of Motorcycle Maintenance'?[13] This notion of quality is much harder to describe, but surely it goes to the very heart of our notions of self-worth, our role, and the role of the GP in future.

I think that a part of good quality care involves a concept of 'hidden care' in that patients benefit from a team who is interested in them as people. This mirrors an important aspect of teaching, namely the hidden curriculum. [14] I have already reported on the role of Care and Caritas [2], and maybe much of our work is part of this ill-defined hidden care role, and that it is the health care team as well as the medicine which achieves any benefits. This concept mirrors views by such luminaries as Michael Balint, which means it may not be fully original, but it is worthy of ongoing consideration and value even if it cannot be easily measured. [15]

A further quality issue could be summarised by suggesting that the best doctors could be those who blend evidence-based medicine (mostly from large studies) with their locally gleaned, personal experience into their overall work. In my view, the skill is to ethically integrate those aspects of either into a more holistic personal style, which requires huge input in terms of ongoing reflection on clinical practice. This is surely a huge positive in the present system of appraisal, in that there are now UK-wide professional requirements to reflect, to learn and to improve.

This qualitative improvement is a necessary part of our work, and involves discussion of experience with a fellow professional, contemplating experience from a variety of angles, and reaching some degree of a 'conclusion', although once again it is not easily measured. This notion of quality is clearly much more than mere measures of QOF points, but in essence considering quality reflects an important aspect of my professional enabling me to continue to learn, to survive and to thrive, and to not get too stuck in inappropriate old ways.too stuck in inappropriate old ways.

Conclusions

For me, an important conclusion to be drawn is that writing has always been a form of organising incoherent thinking, and that learning lessons and reflecting on them should become second nature for all doctors during their career. Once again, this emphasises the positive role of the revalidation processes.

Secondly, it is important to try to stay young at heart and to try to maintain an open mind – in short to 'stay forever young', in thinking at least, as suggested by a famous Bob Dylan song. It is part of history that the young should strive to overthrow the old to become the new leaders, and as an older GP I respect this ever-changing order. However, I hope that some of my perhaps old-fashioned views and values will remain a cornerstone of future general practice.

Thirdly, it is important to recognise that styles of medicine and medical care go in cycles, and that to appear unwilling to change may reflect styles that have been tried before. This may make older GPs 'old dinosaurs' but it is not because we are being deliberately obtuse (well, not always…). However, my generation may recognise, as both experienced clinicians and as 'imminent patients', that the incremental 'benefits' of certain therapies may not be as great in the mind of experienced older doctors. In this respect we may not 'behave appropriately' as viewed from the perspective of younger doctors who may perhaps be more doctrinaire in their thinking.

Finally, it is important to finish on a positive note, primarily because this is not a rant about things being better in the past. My career has given me so much inner professional satisfaction, and hopefully has helped my patients and their overall health, and also my undergraduate medical students to become vibrant doctors. I am not burned out or overly fatigued, and I have not finished helping both patients and students. Hopefully, I will continue to achieve this through a combination of knowledge and wisdom as defined by a maxim from the Tao Te Ching, namely that 'the wise man is not learned, the learned man is not wise'.[16]

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