FOR DEBATE: IS IT ETHICAL TO USE BEING A DOCTOR TO HELP YOUR TREATMENT?

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It came as a surprise when, sitting at an enjoyable alumni lunch at my old Hospital - after several glasses of wine - I (almost) passed out. It did not last long, but enough for my neighbour to enquire if I was OK. A couple of days later, hurrying to catch a train, I became a bit short of breath with a tight feeling in the chest (was it a pain?). It went off on the train.

A few more days later, following a dinner, more chest pain meant that I could only walk very slowly the 100yds to the Underground. I arranged an early appointment with my GP – for a week later! - but as we had arranged a long week-end Eurostar trip to Brussels (for FEAC Bureau) I found an old GTN spray in my 'bag' and set off. Some of the time there was spent at the conference (medical, it's true) but we did plenty of exploring and sightseeing with no ill effects whatsoever. The day after my return I saw my GP who wondered if I had been seeking European treatment (no) and referred me to the urgent access clinic as 'I would probably need an exercise ECG'.

A week passed with no news. I was still getting mild symptoms so I rang the clinic and learned that my appointment was still another week ahead (2 weeks in all!). Before then, however, I had a more troublesome bout of pain after hurrying across the road to hail a taxi. A couple of nights after that, in the early hours after returning from the toilet, I had the pain in bed and after it had persisted for ¾hr, in spite of GTN, we called 999.

How things have changed. The last time I had had dealings with such an emergency (as emergency GP for the practice) it was me who was doing it, armed with my medical bags and the practice ECG. This time the first to arrive was the para-medic who assessed me and was shortly followed by the ambulance. There was no question of persuading a reluctant somnolent foundation doctor to accept the case and I was efficiently bundled aboard and rushed to A & E. how times change. Years ago I was been told off by Casualty Sister for not having seen the patient and arranged the admission myself.

There were no abnormal findings so, after 12 hours in the emergency assessment unit, I was sent home. Three days later I was seen at the Urgent Access Clinic. The Registrar listened to my story, reviewed a new ECG and all the results from my admission, and diagnosed 'atypical chest pain'. He turned to the computer, called up the NICE guidelines and apparently found nothing to be indicated for an 80 year old! He went to see the consultant who evidently agreed that the matter need not be pursued. I was discharged.

Five days later, on the Sunday evening, I found I got pain strolling 50yds on the flat to a neighbour's house. At this stage I admit I 'pulled rank' and rang the surgery on the Monday to demand that the senior partner (my GP being away that day) should call me back as soon as he was free. He did so and quickly persuaded a consultant to arrange an urgent angiogram at a London teaching Hospital.

When, in the early hours of the next morning I had another bout of nocturnal pain, not relieved after an hour with use of the GTN, we again called 999. Cardiology ward this time! My Troponin was found to be slightly raised and I was scheduled for an angiogram. After a days delay to rectify a low potassium angiography was agreed. After a tedious week-end a 'slot' at the teaching hospital was vacant on the Monday, when a stent was fitted. On the Tuesday I was sent home

No out-patient appointment was even mentioned and one lot of tablets, prescribed for 6 weeks, was supplied for 4 weeks only. My GP has had to do a lot to make things happen.

While I hope I did not put too much extra burden on the staff and felt in crisis that I had to mention my past status to fellow patients when unavoidable.

CONCLUSION.

On balance I think being a doctor does help!

COMMENTS FROM A RETIRED DOCTOR.

1, Always listen to the patient's history.

2. Always think. If you must use it, please do not regard NICE as the final word. It should be followed with discretion, not slavishly.

3. Early follow up would help the patient and possibly save readmissions. An appointment would give the patient much more confidence in the system and could resolve all their concerns. I would have liked someone to have explained why I am now on 6 sets of tablets – just because NICE says so? But equally why was my clopidogrel discontinued after 6 weeks (everyone else got a year). I did explain on a ward round that I was reluctant to go on Warfarin (having run a clinic for some years), notwithstanding some short bouts of atrial fibrillation up to 6 years ago, but I never received a clear explanation of why it was considered desirable now

4 Clinical examination seems to be a thing of the past? Most of the doctors listened to my heart and one of the registrars did feel my abdomen but nobody, not even the ward student, did anything like a full examination, let alone a neurological examination. But if you can only treat patients whose disorder falls into your particular speciality I guess you don't want to know what else might be wrong with them.

REFLECTION. ARE WE AS PATIENTS BETTER SERVED NOW BY THE NHS THAN WE WERE?

I had been a locum medical registrar at the same hospital 40 years ago and recall one particular case. Called up to see a coronary admission in the middle of the night I found him OK and snooped around the other admissions. One was a middle aged, slightly obese male, had been out for the evening enjoying beers and scampi, had then been very sick and developed severe chest pain. His ECG was suspiciously normal and I decided I needed chest Xrays, lying down and sitting up. I called in the duty radiographer from his home (they are on site all the time now). A little later he rang to say he couldn't do it because the chap was in too much pain. I remember telling him that he must and that if necessary I would come and hold the patient myself. There were fluid levels in the chest. I called the Surgical Registrar who came and repaired his ruptured oesophagus there and then. He survived! I wonder what would happen to such a case now? Could a cardiac patient ever be recognised as a surgical problem?

I have the impression that the NHS is excellent (in my case an 80 year old with a less than 5 week history from start to 'cure'). But what happens if a case doesn't fit the standard pattern? Maybe that's when being a doctor helps.

OUR COMMENT

Dear Dr Jessiman. We are very impressed by your ability to ignore symptoms do do the things that you knew you should!. Going to Europe with crescendo angina armed only with a GTN spray could only be done a by a proper doctor. Pulling rank to insist upon treatment is merely a means of communicating in a difficult situation. It worked well. And you were right, you truly needed treatment.

We wonder if in fact a layman might just have gone back an extra two times till he was treated. Sometimes they do that and live, and sometimes they do that and die. Others who do not insist may die or survive. And you are right, differential diagnosis counts for all.

You seem to have benefitted (thank God) from real opportunities of curative medicine which were not available in the past. 40 years ago you would doubtless be watching us from the Celestial grandstand.