So many precious stories: a reflective narrative of patient based medicine in general practice, Christmas 1996

Glyn Jones Elwyn

General practice involves the skilful use of relationships¹ above all other resources, including the judicious use of time.² The ability to cope with uncertainty, exclude the dangerous, ignore the irrelevant, and decipher almost incalculable individualised risk-benefit equations³ is not an immediately obvious requirement; but it comes with the job. Day to day, the work is typically made up of two-hourly sessions, sequences of short private dialogues, mostly picking up conversations previously left off, with a few new encounters. Like many other sorts of conversations they are episodic, longitudinal, and intensely personal.⁴

This description of 17 sequential consultations just before Christmas 1996 aims to depict one evening's accidental assembly. It is a reflective narrative⁵ that avoids the split between mind and body which medical training imposes and shuns the critique that as a profession we suffer the peril of "stunted emotions."⁶ By using less strategy, more feeling, better theory,⁷ I wanted to explore the credibility gap in general practice research, and the difficulty of incorporating external evidence into messy chats about illness.⁸ Modified by our faulty memories, the medical literature, with increasing "evidential" enthusiasm,⁹ colours our portrayal of harm and benefit, but these consultations defy logic, bayesian or otherwise. Enmeshed in context,¹⁰ they are about that mix of emotions in which patients¹¹ and doctors¹² engage during these short meetings about life. The session lasted 170 minutes, with eight minutes on average for each patient.

The appointments

Violet

She didn't arrive. I entered DNA in her notes and counted how many times this abbreviation appeared over the past six months. She had injected heroin, and much else besides, since the age of 16. Now aged 53, she would have been at her most psychedelic in the early 1970s. Her clothes had hardly changed, but her veins were shot—apart from the femoral, which she still used occasionally. One recent consultation had been about a lack of sensation in the clitoris and the resulting loss of sexual enjoyment. Perhaps, we speculated, an injection had damaged a branch of her femoral nerve. What could I do about it . . . ? It's a right pain when patients don't turn up for appointments, but it's sometimes bearable.¹³

James

A year after a road traffic accident he was still seemingly stuck in depression and had come for his repeat prescription. He had taken at least two previous antidepressants, and the community mental health team wanted, he said (passing me a self-carbonating form), his general practitioner to prescribe venlafaxine for him—a new selective serotonin reuptake inhibitor—even though the mental health trust had taken all such drugs off their formulary on the grounds of cost.¹⁴ I felt pushed into prescribing, a scribe for somebody's decision, reflecting at least that nobody really knows what's cost effective.¹⁵

A partner had left the practice six months ago, and James was finding it difficult to pick up the thread with another doctor, reluctant perhaps to engage again and tell his story. The "last-minute-must-be-seen-tonight" attitude did little to help. He had seen every partner in the practice. Watching him swing his keys around his index finger as I wrote out another sick certificate I got the feeling that he was better, despite everything, and that he didn't want to unpack his emotional suitcase yet again. But perhaps it was my body language, quietly saying, not tonight.

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Sally

She came for her result. The ultrasound scan had revealed a fibroid uterus. Did that mean cancer, she wondered. No, definitely not. She was petrified at the thought of having a hysterectomy. Not that anybody had made that suggestion. She just thought it was the next logical step. The summary at the front of the file revealed her considerable experience as a patient—meningitis in 1970, a cholecystectomy in 1978, followed by sterilisation, cone biopsy, and removal of a fibroadenoma. Now 44 years old, she had menorrhagia. She consulted at least 10 times a year, double the average, and her records documented a life of anxiety and misery, complicated by a family almost at war with one another. She could well do without her heavy periods. An *Effective Health Care Bulletin* had succinctly highlighted the most useful treatments.¹⁶ The “independent” primary care medical adviser had recently shown how the authority’s spend on the recommended drug had increased and was suggesting alternatives. But, high on the evidence hierarchy, several randomised controlled trials have apparently shown an effective intervention. Evidence based or not, Sally would want something which worked, and she would certainly let me know if she wasn’t happy. “Let me know how you get on,” I said, and scooping up her shopping bags, she went for her tranexamic acid. Our very own trial, n of 1.

Ray

Glancing at the notes, I noticed he’d been seen two months earlier for a repeat prescription and a certificate. The registrar in the practice had started this 22 year old barman on a selective serotonin reuptake inhibitor. The notes showed that there’d been definite biological features of depression—lack of concentration, insomnia, early morning waking, and a general loss of interest. Leaning back slightly, I asked about his work. He was a bit evasive at first but started to talk. He described the difficulties he’d had, becoming distressed as he struggled with his anger, and then tears appeared. Denied an opportunity for promotion, he felt humiliated and resented the manager who seemed to be favouring others, calling at his flat, questioning the validity of his sickness absence. This, for him, constituted harassment. Should I give my opinion? I didn’t, and the pauses continued. The rights and wrongs of this situation apart, he was without doubt ill as a consequence. Tossing the empty box of *Prozac* on the table, he folded his arms. He didn’t really want antidepressants, hadn’t taken them for three weeks. He’d heard about our practice counsellor and I arranged an appointment—another referral avoided perhaps.¹⁷ He left—head down, folding his sick note—heading for unemployment and what then?

Claire

Claire didn’t arrive, and I tried to work out why she hadn’t bothered. Her most recent consultations dealt with her menstrual cycle—breakthrough bleeding and a persistent vaginal discharge. Every test had been negative, including a high vaginal swab, chlamydia screen, and midstream urine culture. She was a few months overdue for her smear, but her last one was normal, so it could wait. Maybe life just got busy—or better, perhaps.

Lee

The problem was sertraline, he indicated briskly. It made him feel sick. I checked the letters from the psychiatrist as he consulted his pink watch. He was also having an intramuscular depot neuroleptic, depixol, regularly, presumably from a community psychiatric nurse, but we had no information about that. The *British National Formulary* listed nausea as a recognised but dose related side effect of selective serotonin reuptake inhibitors, likely to occur early in treatment. He had been taking sertraline for at least a year, yet this was a new complaint. His psychosis was well treated, and he was adamant about the symptom. I was unlikely to get hold of his psychiatrist tonight, and it was clearly his wish to stop the antidepressant and come back again next week. His university degree had been interrupted by schizophrenia, and his inherent intelligence gave him an edge over most patients. He had been seeing me and his psychiatrist regularly for about two years, all three of us negotiating a way through the varying expression of his illness. It was shared decision making,¹⁸ in uncharted waters.

David

He was spurred into action by a weekend medical columnist—his anxiety overtook his retirement. Clutching his hat, he was waiting for his results. The prostatic specific antigen concentration was 10 ng/l. I didn’t want to tell him the result, and I keep asking myself why I perform this investigation when there is so much debate about its usefulness?^{19–20} What significance did a concentration of 10 ng/l have in a 70 year old man? Did that mean that he had early cancer of the prostate? Probably not. But if so, what was the treatment of choice? There are no clear answers, and watchful waiting is arguably as good as any other ploy.²¹ Most men die with their prostatic cancers, not because of it, I kept remembering. Everything had been normal—rectal and abdominal examination, kidney function, urine, the lot—and he hadn’t been bothered by his symptoms. Getting up about twice a night was something he had accepted, and, in his opinion, definitely not worth an operation. But now, alerted to the possibility of cancer, he was impervious to reassurance. If I could have obtained fully informed consent, would he see it differently?²² Was I being inappropriately fatalistic about another man’s existence? Or was I struggling with my own ambivalence, witnessing perhaps another unnecessary medicalisation of life?²³ Uneasy, but as instructed, I picked up the phone to arrange a private appointment.

Sharon

Listen, and you will be told the diagnosis. Not in neatly packaged terminology, admittedly, but in one sentence I had enough to go on—it was irritable bowel syndrome. Crampy abdominal pain with sometimes constipation, sometimes loose motions. From that point onwards I was on the hunt for confirmatory clues,²⁴ and found them, pattern recognition in full swing.²⁵ Working as a nurse on a medical admission unit, she admitted that her full time work, three small children, and travelling husband left little to chance. Aged 37 she had gained weight over the last few months. An abdominal examination was normal. Was there a possibility, however slim, that this set of symptoms could indicate a sinister bowel problem?

Should all avenues be enema'd? I didn't think so. I shared my diagnosis, and she sighed an audible relief. She had read about irritable bowel syndrome, would have been concerned perhaps if I had suggested other possibilities. We were on the same wavelength, gleefully recognising our non-verbal resonances. We discussed the role of stress and fibre briefly, but that wasn't the point. She had told me what she already knew, and fortunately, I had listened. Picking up her car keys, she asked what my name was.

Ryan

"URTI, Rx amoxycillin"—the most common event in primary care abbreviated (an upper respiratory tract infection, a cold in other words, but with enough concern all round to prescribe an antibiotic). We all do it, some more often than others. Prescribing an antibiotic for a presumed viral illness is logically invalid but sometimes provides irritatingly irrefutable anecdotal clinical benefit. Justifying such decisions really depends on your point of view, on so much of the context. A mother, distraught by the prospect of a sleepless coughing child wants tangible help. It's why she's booked the appointment, parked the car, and reorganised her tight schedule. It's a fine balance. Mothers are innately astute and understand so well the need to do their children no harm. There is no closer bond, and at our peril do we ignore their concern. I tend to share my indecision, lean towards home remedies, boosting the need to cope—always trying to sense the mother's views—and when we prescribe we are never wrong.²⁶

Dylan

Dylan breezed in alone, in stark contrast to the consultation that had preceded this easy liaison. An epileptic since the age of 2, he had been on anticonvulsants all his life. Phenobarbitone, phenytoin, primidone, carbamazepine, various combinations suggested by different registrars over the years, never the same outpatient opinion twice. Three months earlier, he had been brought by his wife, who prompted him to "tell the doctor" about the dizziness, irritability, and tiredness. His epilepsy control was, as ever, adequate. He complained of a few blackouts but was used to that, and nobody had shown much concern before. But his wife wasn't having it. He was hell to live with and "surely there must be something new they could try?" Almost hesitant, as fundholders are at times, I remember dictating a referral to a new neurologist with an interest in epilepsy. He confirmed that Dylan was "fairly content" with his treatment but perhaps "troubled by the sedative effects of his medication." The formulation of carbamazepine was changed and lamotrigine introduced. And hey presto! Now he was allowed to consult solo, his symptoms had vanished, and, having "put up" with his previous tablets for many years, he was now delighted with the new regimen. To make life a bit easier for both of us, he asked for a three month supply. I quickly checked the *British National Formulary* before completing the prescription, aware that these drugs don't come cheap. A three month supply of lamotrigine and modified release carbamazepine would come to about £200. Our drug budget was already overspent but how could I put a price on this new found quality. As he put on his gloves, I said, "I'll see you in March," remembering

Cochrane's insanely optimistic slogan "all effective treatment must be free."²⁷

Charlotte

I had seen her last night, given her oral steroids and antibiotics and had asked her to come back. After walking up the stairs to the consulting room she was very short of breath, struggling to complete her brief phrases. Her peak flow rate was 460 litres per minute—not too bad—and really did not reflect the difficulty she was having. Although she mentioned a few attacks over the past two years, they'd always settled quickly with oral steroids. She was taking high dose inhaled steroids regularly²⁸ and had increased her, usually intermittent, use of inhaled salbutamol over the past few days. I had asked her to come back so that I could check her condition before the weekend. Her condition was worse, and I was considering admission. She was not at all keen to go to hospital, so I eventually located a nebuliser machine in the treatment room (we are supposed to have three, but they inevitably get "borrowed" and disappear). The chances were that she would improve quickly, and at least I had taken some pressure off the local hospital, who were full to the brim, as usual. I vaguely remembered that there had been reports of an increase recently in deaths caused by acute asthma attacks,²⁹ and that over-reliance on a nebuliser should be avoided. Should I have insisted on admission? I was taking an uncalculated risk. She had firm instructions to call if things got worse, but even so, I was dealing with uncertainty, and it felt distinctly uncomfortable.³⁰

Gaynor

It was the acid, and she wanted to know if there were any tablets that could help. The raspy voice and the "let's-get-this-over-with" way of sitting signalled that there was something going on here. Her endoscopy, two years earlier, had shown a hiatus hernia, and she had been back once or twice for an H₂ antagonist. There had been nothing in the notes for months. Now here she was today, determined. Puzzled, I casually mentioned cigarettes—a couple maybe, with a drink, you know, on Friday nights. I asked if anything had helped her so far with her acid. Yes, she said triumphantly, her mother was giving her *Losec* and could she have some please. Caught in a budget-shrinking proton pump war—omeprazole versus lansoprazole versus pantoprazole—I negotiated my way gently into a discussion about lifestyle modification. Her dismissive smile rounded us off. I assessed her readiness to change,³¹ and we "got-on-with-it."

Arnold

Unable to see his regular doctor because she was on annual leave, he'd come for his repeat prescription. It shouldn't have happened to this man, of all men. He had always suffered with his "nerves," barely containing a chronic anxiety state without the aid of drugs. Now his wife had unilaterally declared that their marriage was finished. She had taken a part time job as a shop assistant when the children were old enough to let themselves in from school. Released from her role as mother she had taken wing. He wanted to "rip her head off" but couldn't because he loved her. She was "out all nights, smoking for the first time ever and wanted her half of the house." "Another few years and

we'd have paid off the mortgage," he said. "Now I don't know . . . my world has fallen apart." And suddenly, putting his handkerchief away, he got up saying, "thanks for listening" then walked out.

Abel

Abel was an hour late for his four o'clock appointment, but I was glad he'd come. This was the 15th appointment in a period of six months; he had attended 10 of them and had been late many times before. He was trying to kick his drug habit, and was making progress, quite unexpectedly, over the past three weeks. Now 26, he had been taking marijuana and crack, among other things, since his teenage years. He had turned to theft and spent a year in prison, remarking how the prison's computer courses had been the best thing that had ever happened to him. Outside again, he was desperate for help, agoraphobic, depressed, and contemplating suicide. Living alone he was at high risk yet declined admission. An urgent appointment at the drug and alcohol service was awaited, but Abel was virtually unable to leave his flat, inhaling heroin ("chasing the dragon" as he called it) until, as he said, he was "completely out of it." He had abandoned attempts to use antidepressants, and I was getting short of ideas. Then things changed.³² His parents, worried sick, came to ask for "something to be done," and Abel, touched by their distress and also concerned that his young brother was experimenting with drugs, felt perhaps it was time to have one more go. He had successfully spent Christmas at his parents' house, was adhering to treatment, and coping with renewed contact with friends and family. For this kind of progress, it doesn't really matter how late you are.

The extras

At the end of every session there are always a handful of so called "extras"—individuals who have indicated to the receptionists that their problem is urgent, requiring an immediate appointment. The evening's session had been unusually tough, and I was late. I sensed my questions becoming perceptibly more direct.

Brian

This middle aged man clasping his electronic organiser complained of a sore throat, a complaint that had recurred twice over the past two weeks. He had some aphthous-looking ulcers on his palate but no exudates on his tonsils and no fever. Unfortunately his notes were missing—misfolded or misfiled—and the computer record blank. It was not a good basis from which to start a negotiation, and someone had conditioned him that "sore throat equals antibiotics," added to which he had already waited half an hour. A case of "Tuesday night phenoxymethylpenicillin" and a missed opportunity to modify behaviour.³³

Karen

Karen had boils on her face and glands under her chin that needed attention. Why these boils should keep recurring was the main concern. They were more than likely to do with her daily distress.³⁴ Her mother had died of breast cancer at the age of 51 two years earlier. Karen and her husband had fractured many limbs six months earlier in a car accident. She had been recently

relieved to hear that, according to the needle biopsy, a breast lump had been declared innocent. She was submitting to a wave of repressed anxiety. I dared not mention the concept of false negatives. Turning the door handle she remarked, "I'm falling apart," and added, "If you ask me, I need shooting." What was it the receptionist said when she brought in my tea? "Only a few extras tonight."

Angelique

Angelique, a 2 year old girl, had developed a rash and a fever over the past few hours. It was an upper respiratory tract infection, the commonest problem in primary care. But her mother's anxiety was raised, understandably, by a recent outbreak of meningitis.³⁵ Unspoken, however, was our joint recollection of a wintry night when Angelique, 3 months old, had stopped breathing. Driving with haste across the city—"come quickly, my baby's gone"—I wondered how we managed without mobile phones as confirmation arrived that an ambulance was on its way. Clutching her child in the hazardous orange-flickering night she was being comforted by her husband. The baby was conscious and breathing. My presence superfluous, the blue lights sped away. Tonight, flicking through the records where the discharge note summarised the event as an "apnoeic attack," I catch the mother's eye. We half-know each other's concerns as we swap reassurances. "Please call if you're worried," I said, and she left.

As I hurriedly put away my fountain pen and struggled, as I do every day, to find my keys, I sat back a moment and looked at the pile of notes strewn on the floor. This is crazy: too many problems, too little time,³⁶ so many precious stories.

The above account is based on a general practice session conducted in December 1996. The patients have read the account and given written consent for publication.

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Do overweight people remove their shoes before being weighed by a doctor? Consecutive study of patients in general practice

Timothy Harlow

Casual observation and discussion with colleagues led me to the hypothesis that patients who are overweight tend to remove their shoes before being weighed by their doctor. I thought that this action was probably an attempt to reduce the reading on the scales. I tested this hypothesis by measuring the body mass index of patients who needed to be weighed as part of their management and noting whether they removed their shoes unprompted. To my knowledge, no such study has previously been performed.

Patients, methods, and results

During the autumn of 1996 I weighed 122 consecutive patients as part of their normal management. I used the same set of scales throughout the study, and each patient was weighed only once. Weights were recorded in kilograms. Patients were excluded from the study if they had difficulty in removing their shoes owing to stiffness, pain, hand disorders, or general debility. Patients were also excluded from the study if their choice of footwear would be abnormally difficult to remove because of complex lacing systems, if they wore boots higher than the ankle, or if their footwear was dirty.

I did not seek patients' consent to the study because the results were anonymous and would not have affected their management. I did not suggest that patients remove their footwear before being weighed but simply asked them to step on to the scales. If patients asked me whether they should remove their shoes I replied, "Whatever," with a Gallic shrug. I took the height in metres as recorded in the notes if it had been measured within the previous five years. If this was unavailable I measured the patient's height using a standard height measure mounted on the wall. I calculated body mass index as $\text{weight (kg)} / (\text{height (m)})^2$.

Seventy four (61%) patients kept their shoes on and had a mean body mass index of 27.8 (SD 6.0), whereas 48 (39%) patients removed their shoes and had a mean body mass index of 28.8 (6.0). Comparison of the two group means by Student's *t* test showed no significant

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difference between them. The average weight of 22 pairs of shoes is 640 g (unpublished data), and allowance for this did not affect the significance of the results.

Comment

Preliminary consideration of this study reflected disappointment at the slaying of an interesting hypothesis by a mundane fact. There is, however, further work to be done on the extended hypothesis that removal of car keys from a pocket before weighing is a certain sign of obesity.

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