Medical idealism in a place of collapse, p 956

"I want to see the consultant"

PERSONAL VIEW **David P Crampsey**

Hospital trainees working in outpatient clinics are familiar with the scenario. The next case record in the pile has a note from the nursing staff saying, "Patient wishes to see consultant." Invariably these patients will get to see the consultant, but why? Are we bowing to the pressure of assertive patients simply to avoid confrontation? Do patients have a right to insist on seeing a particular member of the team? Patients wishing an exclusively consultant led service are already well catered for—in the private sector. However, the NHS is founded on principles of equality of access, and it also exists to provide training to junior medical and nursing staff and those in professions allied to medicine.

Some patients have a long established relationship with a particular consultant. Consultants themselves may express a desire to see particular patients: "I will see Mrs X with condition Y." For patients who have had a less than satisfactory outcome after an operation or other intervention, it is often appropriate that the consultant continues care and re-establishes confidence in their relationship.

Are we bowing to the pressure of assertive patients simply to avoid confrontation? Do patients have a right to insist on seeing a particular member of the team?

However, patients' insistence on seeing the consultant can simply be an example of an assertive patient attempting to gain an unfair advantage. In demanding what they presume will be a superior consultation, they thereby deprive less vocal fellow patients. This is both ethically and morally questionable. Patients are not able to insist that the ward sister instead of the junior staff nurse looks after them when they are inpatients, so why should the situation with medical staff be any different?

Furthermore, there is an implicit criticism of all staff below the level of consultant who are working at the clinic. The inference is that junior doctors are less knowledgeable and less experienced. This may well be the case; however, an integral part of training comes from arriving at diagnoses through history taking, eliciting clinical signs, and "consulting" with senior colleagues. Trainees will consult with their consultant when unsure, to confirm diagnostic findings, and to share interesting and challenging cases. In some situations trainees may even have more recent experience of a particular condition, having just rotated from that subspecialty, completed out of programme research, performed a recent literature review, or indeed undertaken a clinical fellowship. Many patients allocated to the junior at clinic will see both the consultant and a trainee. A rule whereby no new patient is seen on three consecutive visits without the consultant having knowledge of their case is instituted in some units to prevent juniors unnecessarily serially reviewing patients with no clear management plan or diagnosis.

I see requests from patients to see only the consultant as an insult and a challenge. Such requests sometimes arise when I am the only doctor at the clinic. On these occasions I bring the patient in, muster as much gravitas and politeness as I can manage, and then endeavour to provide as comprehensive and confidence inspiring a service as my most respected trainers would effortlessly provide. I have had occasions where that patient has then asked to see me at the next clinic instead of the consultant. Although this is flattering, I am in no doubt that as the trainee my knowledge and experience are incomplete; I have no hesitation in seeking the opinion of the consultant in the next room, to whom I defer regularly.

We should not underestimate the importance of trust in the doctor-patient relationship. Continuing care for existing patients may be best delivered by the doctor who is most familiar with the case; equally, the second opinion provided by another doctor within the same team is of value and can offer a fresh perspective.

However, for most patients at outpatient clinics, requests to see the consultant should be acknowledged but politely rejected to ensure equality of access for all and to maintain the professional respect of all team members.

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REVIEW OF THE WEEK

A place where dreams turn to dust

A daily blog from an aid agency medic in Sudan, now an insightful book, dashes the romantic notion of achieving medical miracles in basic conditions, finds **Jonathan Kaplan**

Six Months in Sudan: A Young Doctor in a Wartorn Village
James Maskalyk
Canongate Books, £14.99, pp 338
ISBN 978-1847672742
Rating: ★★★★

From a distance it seems easy, signing up to a humanitarian mission. Most doctors, at some stage in their training, dream of working somewhere extreme, applying their skills to alleviate the suffering of those caught in a disaster, a conflict, a refugee crisis, some place where a little doctoring goes a long way. There is the romantic notion that with basic equipment and idealistic resolve, medical miracles will be achieved. But the journey is vastly more complex, the rewards far less definable. All of us who return from these places leave something of ourselves behind.

James Maskalyk was a young, recently certified emergency medicine specialist in a Toronto hospital when he accepted a six month assignment from Médecins sans Frontières (MSF) in 2007 to be a doctor in the contested town of Abyei, right on the fracture line between North and South Sudan. He did so because he wished to help, but also because he wanted to explore that particular self realisation that is acquired through hardship and abnegation; because, as he admits, he wanted to be close to war and its consequences. His discoveries might have remained personal ones, but Dr Maskalyk chose to make them generally accessible. In the face of some resistance from MSF—like all NGOs, mindful of its image—he elected to write a blog of his daily experiences in the field. Those writings, visceral and immediate, form the core of *Six Months in Sudan*.

As medical literature this book excels; as an insight into that exhilarating, life changing step into chaos—walking towards death, Maskalyk calls it—his account can hardly be bettered. The consequences of his decision form the start of the narrative, in a first chapter entitled *The End*. Back home in North America, at a happy wedding party, Maskalyk finds himself suddenly overwhelmed by memory, starkly aware of the "irreconcilable invisible distance" between himself and those who have never embarked on such a mission. "Though I could convince myself that the fissure was narrow enough to be ignored," he observes, "it took only a glance to see how dizzyingly deep it was."

From that point he moves to try to understand *The Beginning*, the steps involved in volunteering. These require the incremental extraction of the self from conventional aspirations, from friends, from—as he comes to realise—the shared moral framework of structured society. It is necessary to shed expectations about certainty for the future. He is taking his idealism to a place where order has collapsed: subsistence replaced by starvation, trade by banditry, schooling by armed militias. An aircraft lifts him to the place where he will be working, across vast tracts of desert. How many good intentions had these pilots ferried over the sand, Maskalyk wonders, how few they brought back. One of the choices he has made, just before departing from MSF's Geneva base, is to buy cigarettes, a self destructive act but one that ends up making perfect sense in the loneliness of his posting; "When you have a cigarette, you always have a friend," Maskalyk will write in his blog after two months in Sudan, "everyone in our mission smokes furiously."

He is taking his idealism to a place where order has collapsed: subsistence replaced by starvation, trade by banditry, schooling by armed militias

A further, essential adjustment is the realisation of the limits of what can be achieved. This is not the place for those who need reassurance that they are doing the right thing, or even the evidence that they are making a difference. The work is not easy, he observes, and it never ends. Rather, it is an exercise in patience, knowing that the war is a long one, that not all projects will go forward or interventions succeed; that it will be difficult enough sometimes to simply do the best you can for the person in front of you.

After Dr Maskalyk has been working in Abyei for some months, the community arranges a meeting through the paramount chiefs to complain that the hospital is not doing enough for them. Some want to be able to get treatment for minor, non-acute as well as emergency conditions; a full surgical service; a helicopter for transfers to other hospitals. Their expectations are unmeetable. When factions in Abyei start shooting at each other, the hospital becomes a point of conflict. Armed men demand treatment for their wounded, post mortems on their dead. Playing the only card they have, the MSF team withdraws its services until the guns depart.

Yet at the same time its work is about much more than medicine. It is a catalyst, a nidus around which the structure of a new, tentative society might coalesce. "The hospital is not just a place to treat the dinka infant with meningitis or the little misseriya girl with malaria," reads Maskalyk's blog, "but a place where their fathers can reach for the water barrel at the same time and say to the other, after you, no after you, and maybe, two weeks later, when they pass in the market, they will nod. And perhaps, two years from now, they might stop and talk."

And therein lies the hope and beauty of this rare medical experience.

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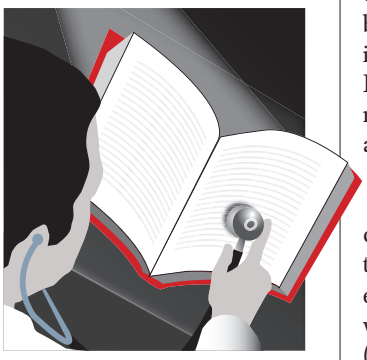
The meaning of things

BETWEEN THE LINES
Theodore Dalrymple



I can't claim that Dr Nardini's words enabled me to be as serene as he. But his words have long acted in the back of my mind as a reproach whenever I lose my temper over something completely trifling

Though I am not, I hope, much given to emotionalism, I often think of people in the concentration camps, in the Gulag, or in Japanese prisoner of war camps when I am eating. I don't know why, because I've never suffered the slightest deprivation, even when travelling in countries ravaged by civil war. Perhaps it's because I had an uncle who was a prisoner in east Asia during the second world war and who was reported to wake up screaming in the night, and perhaps because my mother escaped the extermination camps by quite a narrow margin. To this day I'd rather eat stale bread than throw it away.

I thought about my uncle for the first time in ages as I read James Clavell's semi-autobiographical novel about his time in Changi camp in Singapore, *King Rat*. Everyone in the camp, apart from a wheeler dealer called King, is practically starving; they are tormented by dysentery, both bacterial and amoebic, and by malaria. At a certain point many men give up the struggle and die. Clavell describes the notorious Ward Six in the camp (a nod in the direction of Chekhov?), where those "blinded by beriberi" were sent. (Does beriberi cause blindness, or is it the associated vitamin A deficiency?)

Clavell's novel also reminded me of one of the most important encounters of my life. Though brief, it was formative. As a senior house officer I was deputed by the professor to show a visiting American, Dr J E Nardini, around the department, because he, the professor, did not have the time for it. I was nervous, because I thought it might appear rude that such a lowly and insignificant a person as I should have been given this task. I needn't have worried because, even if he noticed the slight, Dr Nardini was the epitome of courtesy.

I don't know how the subject came up, but he told me about some of his wartime experiences. He had been captured early in the war in the Pacific by the Japanese and spent three and a half years in a prisoner of war camp. Sixty per cent of the inmates of the camp died of disease; at liberation, he weighed 60 pounds (27 kg). He had severe beriberi and could hardly walk.

In 1952, as I later discovered, he wrote a paper in the *American Journal of Psychiatry*, "Survival factors in American prisoners of war of the Japanese" (1952;190:241-8). In it he came to the perhaps unsurprising conclusion that people who were healthy, intelligent, courageous, and strongly moral or strongly opportunistic and who had a sense of humour were more likely to survive than those with the opposite qualities. About 18 000 died in his camp.

Now, of course, Dr Nardini looked extremely sleek and prosperous in a smart blue suit. You would never have known that he had experienced anything so terrible. I felt a very callow youth beside him. Then he said something I have never forgotten: "In the context of my whole life, I'm glad that I went through what I went through. It taught me what is important in life, and I have never been unhappy about anything trivial since."

I can't claim that Dr Nardini's words enabled me to be as serene as he; the wisdom of others never works like that. But his words have long acted in the back of my mind as a reproach whenever I lose my temper over something completely trifling, which is more often than I should like. Perhaps with the reinforcement of Clavell's novel, I'll improve.

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MEDICAL CLASSICS

The Motorcycle Diaries By Che Guevara

First published in 1993

When he started these diaries in 1952 "Che" was just Ernesto Guevara, a 23 year old Argentinian medical student who knew that what he was writing was "not the tale of impressive deeds but the description of two lives that in a moment in time were together with a common aim."

That aim was to travel around South America, initially by motorcycle, with his older friend the biochemist Alberto Granado to learn about leprosy; but Guevara's experiences in hospitals and clinics across the continent had made him a "different person" by the end of the journey. The book's many medical references allow the reader to get a sense of the state of health care that the middle class student found.

Leprosy was, as Guevara wrote, "unknown to our transandine colleagues"—a reference to the Chilean doctors who told them only about a small leper colony on Easter Island. But in Huambo in Peru they visited a basic leprosy hospital with 31 beds, which Guevara found bearable only for the "fatalist and uncomplaining Peruvian Indian from the mountains." It had "terrible" sanitary conditions, no surgical equipment, no laboratory, and was infested with mosquitoes. In Venezuela they lived in the San Pablo leper colony, where 600 patients lived independently in huts. He noticed that the patients in this area were particularly affected by nervous system symptoms of leprosy and that the disease appeared precociously in children. In Lima the two travellers met Dr Pesce, a famous specialist in leprosy, whose leprosarium impressed the two young men with its excellent bibliographical archive, despite a poor laboratory.

At times his observations resonated with his own experiences, as Guevara had asthma. The illness featured strongly in their day to day travel: Granado injected him with adrenaline, and Guevara described using "a French insufflator," despite which his symptoms worsened when they travelled by boat down the Ucayali River (a branch of the Amazon). But he also wrote about his role as a future physician: after a consultation with an elderly woman with asthma in Petrohué, Chile, who also had cardiac problems, he reflected on the "physician becoming aware of his total inferiority against adverse conditions."

Guevara's reflections on different countries' healthcare systems are of much interest. He devoted a full chapter to the situation in Chile, which had "few free hospitals, poorly lit operating theatres, general dirtiness, no sanitation in the toilets and few instruments." The situation in Peru was even worse. While travelling on the zigzag railway line from Cuzco to Machu Picchu he noticed the poor hygiene among the indigenous population, which, he said, resulted in many "foci of infection." He believed that the lack of hygiene was the main reason for the terrible living conditions in Peru.

Guevara was so struck by the Latin America he discovered that he decided to become a part of its history. More than 40 years after his death he is still a controversial figure, as shown, for example, in the responses to the *BMJ*'s review of the 2004 film that was based on the diaries (*BMJ* 2004;329:518).

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Doing it by the book

FROM THE FRONTLINE
Des Spence

It's exam season. I recently happened upon my old English exam paper and stirred some old memories. The invigilator's jangling keys, sun streaming through the windows, and students slumped at graffitied desks. I chewed my pen as I wrote a comparison of George Orwell's *Nineteen Eighty-Four* and Aldous Huxley's *Brave New World*. As an intense teenager I felt comfortable with dystopia. And with the return of broodiness in middle age I wonder if these fictional novels have any resonance with today's wealthy utopia.

Nineteen Eighty-Four is a vision of extreme authoritarianism. A malevolent Big Brother is constantly watching, with a culture of fear, suspicion, and informing. Restrictions are placed on the population for their own protection. People subsist on a diet of synthetic meals and cheap "Victory-brand" gin. Love is derided and individualism crushed under the boot of the greater good. A simplistic reductionist language called "Newspeak" bombards the population with constant propaganda. Even free thought is controlled through the thought police and "doublethink" (ideas that are utterly contrary) is unquestioningly accepted as valid. It is harsh, but Orwell's vision has similarities to today's centralising NHS.

Messages are ever simplified and the organisation is increasingly intent on controlling language and even thought. Employees are monitored and patients are increasingly suspicious of our advice. Professionalism is ebbing away because trust is being replaced by fear. And now there is a new super-regulator, the Care Quality Commission, who talk of cooperation but whose real language, such as threatening to close failing units, is one of coercion.

Huxley's vision, however, was of a consumerist and individualistic dystopia, where casual sex and mood enhancing drugs become state policy. Society is separated into castes dependent on intellect. The underclass of Gammas are ignored and sterile, left to a drug induced oblivion. The society is so undone by consumption and desires that literature is not banned but irrelevant. Youthfulness is deified and life ends at 60. But no one can remember what it is like to have a family, as even humanity is mass produced in factories.

Perhaps this literature review is no better than my naive adolescent one, but if nothing else we should appreciate literature's relevance to medicine. Set medical school textbooks should include the great social classics and perhaps humanities studies should be expanded for medical students. For surely it is important for doctors to be challenged to think rather than merely encouraged to learn.

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The appointment quest

STARTING OUT
Kinesh Patel

My fiancée has a mole. A small mole, on her left leg. Better get this checked out, she thought. So, she went to her GP, who thought it warranted a specialist opinion. So far, so good.

The next contact she had with the NHS was a letter from the Choose and Book service. This was not asking her where and when she would like to be seen, as you might expect. Instead, it admonished her for not having attended her outpatient appointment, which, of course, she had never received. And then she received a second letter, a few days later, echoing the sentiments of the first.

No doubt an appropriately chastising letter will be sent to her GP along the lines of "this patient failed to attend their appointment." We all write them, usually with the subtle implication that the patient couldn't be bothered to attend and didn't even deign to let the clinic know. The letters are invariably filed in both the hospital notes and the GP's notes, labelling the patient forever as a non-attender, a person whose compliance with all future medical advice will be suspect.

In government speak, the whole episode was an unmitigated success. She was referred, given a rapid appointment, did not attend, and was discharged. Episode closed, one less patient on the waiting list (and within 18 weeks, no less).

Perhaps she won't be bothered to go back again. All the boxes on the patient pathway pro forma are ticked; the managers are happy. And the doctors certainly won't be doing any nasty expensive blood tests or biopsies on an invisible patient.

Luckily she's educated and concerned enough about her health to go back and let the cycle begin again, in the process wasting an appointment slot with the GP. But many lack the insight, the time, or even the inclination to return to arrange a new referral.

This keeps the waiting lists down, but, as with all health inequalities, it disproportionately disadvantages the poor and less well educated, the very populations most likely to be affected by serious illness.

As Jacques points out in *As You Like It*, it is ironic that people at the most vulnerable stage of their lives—often "sans teeth, sans eyes, sans taste, sans everything"—are treated like children, and all in the rather illusory quest for patient choice.

For what most people want is to be seen quickly, by a competent doctor, near where they live. Is that really beyond the wit of man?

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