All in a day's work

Jenny Bulman

My husband was happily disembowelling his car, the children had gone swimming, and Sunday lunch had been cleared away. Even on such a scorching day our children would have considered deprivation of the traditional roast and two veg as a matter for reporting to the National Society for the Prevention of Cruelty to Children. As I headed for my sun lounger in the garden, however, I reflected that it was an easy meal to prepare if I was busy. Normally I never did assessment visits on Sundays, but when I had telephoned to make an appointment Mrs Walters had asked me to meet her son from London who would be with her that day.

As I settled down to boost a rather feeble sun tan I thought back to the visit. Mrs Walters had gastric carcinoma, which was causing her little in the way of troublesome symptoms at present. Her general practitioner had referred her to us to see if we could help give her unmarried daughter, who lived with her, a respite from caring. The old lady adamantly refused admission to hospital or hospice. Although Mrs Walters had accepted her illness, her son and daughter refused to discuss it with her and presented a constant barrier of forced cheeriness which she found difficult to break through. While I examined her she told me of this. She asked if I would answer all her queries openly when I met her family to discuss how the hospice might help.

Realistic attitude

Later, having coffee, I tried to do this by following her leads in the conversation, and the family could see how realistic her attitude was. We were able to cover many different aspects of their concern, and they were pleased to hear how our local family volunteers could give her daughter regular time off. Thanks to the old lady's determined strength of mind the atmosphere was much less tense when I left and the family was happily discussing plans for the daughter's first outing in months. When I reported back to the general practitioner the next day I thought he would agree that this was the kind of resource he had wanted from us for his patient. But when I had examined her abdomen it had been apparent that she had developed a degree of ascites. If this increased and caused her discomfort she would resist being admitted to hospital to have it drained, even for 48 hours. When discussing my visit with her doctor I could ask his views on carrying out paracentesis at home and offer our team's help with the procedure if he wished. We had often done this before, though not for doctors in that practice, and the patients appreciated avoiding the upheaval of repeated admissions. We had shared care with this doctor before and I felt sure he would agree.

Not for the first time I was thankful that in setting up our home care hospice I had emphasised the need for the team doctor to examine patients clinically at assessment. Even if they were referred only for support for the family this was important if we were to deliver a useful, comprehensive service. Some doctors had

demurred at first, with understandable anxieties about sharing care in quite such a detailed way, but as the service flourished its value was becoming steadily more recognised and accepted.

I had had an unexpected call during the night, which had left me rather short of sleep, and the hot sun was making me pleasantly dozy. A family in the county town seven miles away had telephoned in some distress. Hilda, the mother, was dying at home and being cared for by her two young daughters. Their father was an alcoholic, had had a few drinks that evening, and had come home maudlin with the booze. He was insisting on sitting up to nurse his wife and attend to her needs, although he could barely stand upright. Hilda's own general practitioner was away that weekend and so the daughters had called me. Their father had not seen any of the other partners in the practice but knew me from my occasional visits. It had been only a matter of sitting with him for a while while his daughter fed him black coffee in between turning her mother and sponging her face, but it had taken time for him to become sober enough to be persuaded to go to bed. He was aggressive with his children but would listen to people his own age more readily. It had not been an emergency in the medical sense but was certainly a crisis to the family. As we had few night calls our service could offer the time needed for such problems more easily than could a busy general practitioner. It was another resource we thought it essential to offer. Provided we were responsible about not acting in such a way as to assume the family doctor's own role there were rarely any problems.

As I drowsed in the hot sun the Sunday peace was shattered by the telephone. The call was from a general practitioner friend asking for help. "This is Chris Jones here. I'm at Bill Burrow's house. He seems to have a genuine intolerance to morphine and I'm wondering what to give him. I know you saw him in hospital for me on Friday and I wondered if you had a note of the drugs he's already had. I don't want to give him something that's already been tried." I flicked over the pages of my book of rough notes. According to his hospital file Bill had found dihydrocodeine ineffective and had disliked oxycodone. It looked as if phenazocine would be the answer. It would be equivalent to his opiate dose and he could take it sublingually as he was vomiting despite the antiemetics he had been given. Chris was doubtful whether the local chemist would have any in stock. Luckily, I knew that a patient in another practice nearby was also taking the drug, so Chris paged our nurse and asked her to take the script in. The Burrows were an elderly couple and knew no one who could run messages for them so our nurse would be glad to do this and to spend some time with them when she took the tablets for Bill's first dose.

All our nurses had had at least six months' experience of working in a hospice before coming to join the team and between them had agreed a policy of weekend rota work which was certainly paying dividends. Visits

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were paid on Saturdays and Sundays only to very sick patients or in answer to special requests, so the work was generally lighter than usual and the girls enjoyed their two days off during the following week. Problems that needed help from hospice trained workers were not limited to office hours and often seemed to surface at weekends, coinciding with the off duty of familiar community staff. Our own nurses had therefore been anxious to contribute to continuity of care in this way.

Encouraging interest in the professions

As I put down the telephone I thought I would just have time to polish up some lecture notes for two talks I was giving in the coming week before I had to start getting tea ready for the family. One was a lecture on symptom control for a group of Marie Curie nurses and should not pose any problems. I had given several talks previously on this subject, and all I would need to do for this one would be to expand the section on nausea and vomiting as they had asked for this topic to be emphasised. The second talk, to general practitioner trainees, was a little different. I was thrilled to be asked to give it as, no matter how we varied the time or venue, the medical profession was generally poorly represented at study days. Evidence of interest coming from the profession was encouraging and it was important to make the afternoon as good as I possibly could. But the brief I had been given—terminal care—was wide and I wondered how best to present the two hour session to be most helpful. Apparently an informal talk was preferred, so I decided to begin by asking the trainees what they most wished to talk about and then to have as wide ranging a discussion as possible based on several case studies covering different topics.

I had just tidied away my notes when the door burst open and the children fell into the house, with seal wet hair and bundles of soggy towels clutched under their arms. They were at the tea table, giving a lifelike

imitation of gannets feeding, when the telephone rang again. This time it was Tom, an old man who had been to visit his wife, Elsie, in the radiotherapy ward to which she had been admitted after I found signs of early cord compression at my assessment visit. Seeing her there, surrounded by other very ill people, Tom had been forced to recognise what he had so far managed to deny—that she was unlikely to recover. “You said to ring if I wanted to talk,” he apologised. It was obvious that he was very upset so I suggested he made himself some tea while I fed my hungry mob. I said I would call round as soon as I could. This kind of visit was not exclusively the task of either doctor or nurse, so whichever team member was best placed to respond would go. Our nurse had already put in a full day’s work, and I lived nearer to Tom than she did.

The familiar act of making tea had calmed Tom somewhat by the time I arrived, but he wept a little and talked of how he was feeling. I heard of how he and his wife had met so long ago, of the holidays they had enjoyed together, of the hopes, never fulfilled, of the family they had longed for. His Christian faith was strong, but feelings of anger and resentment troubled him and we talked about this for a while. When I left nothing had changed except that he said talking had “cleared a lot of rubbish away” and he now felt strong enough to take up the challenge ahead of him for a while longer, for both their sakes.

I got home in time to put the neglected sun bed away and my youngest to bed. In the twilight garden my husband was watering some flagging runner bean plants. I took up my work watching pose. “If you go on doing that it’ll rain for sure.” He laughed. “It’s bound to do that anyway if you’re off duty next weekend. Has it been a bad one this time?” We went into the house as the second wave of midges moved into the attack. “Bad?” I thought of Mrs Walters, of Chris Jones and his patient, Bill, of Hilda and her poor family, and of Tom and Elsie. “No, not really. Not a bad weekend at all.”

The last game

Erl Annesley

I was home later than expected from my golf dinner that Thursday and there was a glass of whisky already poured and waiting on the kitchen table. I seldom drink whisky and I was looking at it with some curiosity when my wife came in from the day room. I could see that something was wrong. “It’s Martyn,” she said very quietly and stood with her arms around me.

Martyn wasn’t my son, or my brother, but a close friend and fellow general practitioner, who had started in practice at the same time as I had in a town some 20 miles away. Although of very different temperaments, we hit it off as soon as we met and remained firm friends for nearly 30 years, swapping stories of practice life, comparing work rates, incomes, and partners, and putting the medical world to rights. As well as regular postgraduate weeks in Brighton and elsewhere we often continued with peer review during our local weekly golf game, and sometimes even further afield when we played over the many beautiful Scottish links.

When the new contract raised its ugly head and there were mutterings about resignation Martyn would remember the earlier crisis in the ‘sixties when we had all sent in our undated resignations to the BMA and insisted that it would never happen. Similar debates were carried on during winter nights at the squash club. There we would meet up with a regular crowd of

general practitioners, consultants, and others of the same age for our twice weekly game. By playing regularly among this same group over the years, giving up smoking, and moderating our alcohol intake, we were able to keep going through our 30s, 40s, and into our 50s.

Often after a Friday night surgery the last thing we felt like doing was playing squash, but when the game was over and we were sipping a cool drink suddenly the batteries were recharged and in the midst of Martyn’s laughter we would all be uplifted, mentally and physically. We had found the way to stave off the dreaded general practitioner burnout, driving our bodies for that last match point, then arguing in the bar afterwards about politics, or air safety, or carpet manufacture, with our fellow mature players.

Hard work counterbalanced with an active sporting life, and good company was the sure way of drawing the NHS pension for as many years as possible. Martyn and I had it all worked out. We would conquer the new contract, see it settled in and working, and then retire to the quiet life, with a week’s fishing here and a few days’ golf there. We might even put in an occasional gentle game of squash.

But there can never be a gentle game of squash.

That fateful Thursday, while playing against a

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