

RCGP William Pickles Lecture 2017: A New Kind of Doctor

11th May 2017

It's an honour to be giving this lecture.

A few thanks...

To my late father, who inspired me to be a doctor

To my mother, who taught me courage.

To my sons, Alex and Ben and husband, Simon,
for their love and competitiveness!

To family, friends and colleagues, for putting up with me.

To this Royal College, for allowing me to lead you –
and for your support during difficult times.

And finally, to my patients, who have been sustaining, exciting, infuriating, but fundamentally a
privilege to serve over the last 35 years.

For the last decade, I've been a doctors' doctor –
leading a confidential service for doctors with mental health problems.

I have seen, and treated, thousands of doctors across
all specialities and ages.

Most present with depression, anxiety, and
symptoms indistinguishable from post-traumatic stress disorder.

Doctors with alcohol and drug addiction.

With bipolar disorder, schizophrenia and personality disorder.

Doctors with what we call 'NHS-itis'

General practitioners, psychiatrists and paediatricians are
over-represented in the service.

Surgeons, on the other hand, are under-represented.

– After all, surgeons never get ill, they get divorced instead!

Over the years, the number of doctors presenting has increased, whilst the average age of those seeking support has dropped dramatically.

In caring for my own kind, I have been trying to understand why it is I'm seeing growing numbers of mentally ill doctors. In this talk I'll share with you my personal experience of what I've learned. And in so doing, will suggest – as Julian Tudor Hart did in the 1980's – that we need to train 'A New Kind of Doctor'.

I'd like to begin by telling you about three people who have been an important influence in my life. All are general practitioners.

The first, I have already mentioned is **my father**. He came to the UK as an immigrant in the 1960's, at a time when the NHS was struggling to cope with an increased workload, an ageing patient population, and the demands put upon it by a new health service reorganisation.

For many years, my father worked as a single-handed GP in the East of England.

Our home, was his surgery.

Our front room doubled up as the patients' waiting room, and our dining room served as his consulting room.

One of my earliest memories is peering down over the bannisters and seeing people – mainly women and children –

sitting quietly whilst they waited to see my father in the adjoining room.

From an early age, I saw first-hand the relationship my Dad had with his patients.

His dedication, his authority – and his love.

When I was a young girl, he would take me with him on home visits – and I was enthralled as he explained what the house call was about, and what needed to be done. He enthused me with a love of medicine, more importantly, though, with a love of general practice. And he impressed upon me how important it was for a good GP to get close to his, or her, community.

The second of my three GPs is **William Pickles**

a Founding Member, and the first President of the Council of [this College] the Royal College of General Practitioners,

whose career was coming to an end as my father was starting his.

Pickles was a much-loved GP in his North Yorkshire community.

He was the archetypal family doctor, regarded by many as a father figure.

Early in his career, he too lived above the shop – in the doctor's house with his practice partner, an old friend from medical school.

Each day, over supper, they would discuss their patients.

They were rarely off duty.

Pickles was totally dedicated to public service.

His work and personal life were so intertwined, there are tales of him even giving away personal possessions – like shoes and clothes – to his patients.

And like my father, he was known for his kindness and knowledge of his patients.

By the time he died, at the end of the 1960s, he'd already become part of this College's, and general practice's, mythology¹.

To these two individuals I add a third.

He's the subject of a book described by a past President of our College, Iona Heath, as the greatest book ever written about general practice.

The late John Berger wrote, 'A Fortunate Man', in 1967,

¹ See the display on the ground floor of RCGP foyer and his portrait hanging.

the year my father set up his practice in Peterborough.

Subtitled ‘The Story of a Country Doctor’,

it’s a portrait of Berger’s own GP, **Dr John Sassall**.

Now, Sassall worked as a country doctor in the Forest of Dean, and Berger accompanied him on his rounds and in the surgery, to produce, what we would call today, a fly-on-the-wall account of his life and work.

In Berger’s book, Sassall emerges as someone who embodies all that’s best about our profession.

He’s described as a saintly individual,

“all-knowing haggard....and accepted by the villagers and foresters as a man who, in the full sense of the term, lives with them”.

Out of personal stories like these emerges an exemplar of the perfect family doctor to which we can all aspire.

Decades later, inspired by my father, I became a GP in South London and have lived and worked in the same place for over 25 years.

I live a few yards from my practice.

And, though located in the heart of the inner city, it feels as much my parish for me as the Yorkshire Dales did for William Pickles, or the Forest of Dean for John Sassall.

Over the years, stories like these have contributed to the folklore of our profession.

But, is the idea of a self-sacrificing, infallible, dedicated [always available] GP anything more than a myth?

Are we in danger of looking at the past through rose-tinted spectacles?

I believe we are.

And I also think that trying to build a future on the foundations of a distorted version of the past,

makes life very difficult for this, and the next, generation of GPs.

So...Let's take a more dispassionate look at the realities behind these stories.

Like my father, Pickles would take his daughter on home visits too.

There is a record that he even took her to visit a dying woman – both Pickles and the girl en-route to a local Ball.

By taking their daughters on home visits, both Pickles and my father could be accused of putting their needs, and those of their family, ahead of their patients.

Even of showing off.

Nowadays, the idea of a GP taking a child with them on a visit to a dying patient is unimaginable.

Pickles was most clinically active during the 1950s – a time when general practice was heavily criticised by a major report, **The Collings report**. Collings surveyed fifty-five randomly chosen practices, and reported finding:

*“...practices with minute consulting rooms with no chair for the patient and no couch for any examination;
queues extending 200 yards waiting to see the GP;
a practice of 4 principles and an assistant seeing 500 patients per day and proud of it;
waiting rooms where patients had to stand for hours before being seen for 5 minutes’.*

And **the Taylor report** – which was published in 1954 – found wide discrepancies in the quality of care provided by GPs, and a stark contrast between what constituted ‘a good GP’ and ‘a bad GP’.

Taylor described a GP to be avoided as:

“stupid, smarmy, pompous, bad tempered, obstinate, refuses to admit mistakes, skimps work and shows emotional instability with querulous self-pity and abuse of patients and society”.

Not surprisingly, these two reports were received by the profession with anger and denial – much as we receive our CQC reports today.

I'm sure my father's practice would have come in for severe criticism too.

When he moved it to a two-up-two-down converted terraced house in the 70s, I was in my teens, and used to work for him as a Saturday receptionist, offering cigarettes to patients as they waited hours to see him.

The patients' lavatory was situated behind the only consulting room.

So, when in need, they had to walk through,
interrupting the consultation.

And, the sound of their bodily discharges was clearly audible.

By the mid-1970s, the Royal College of General Practitioners was beginning to have an influence on general practice,
even in Peterborough.

But not in the way you might imagine.

When my father decided to take on a new partner, I remember him rapidly sifting through a mound of applications,
and separating them into two piles.

I asked him what the piles meant, and he said
the first was for those with MRCGP,
and the second for those without.

He went on to reject all those in the first pile.

The new kind of doctor being promoted by the College –
one specially trained and qualified to deliver high quality general practice – was clearly seen as a threat to my father.

And what about John Sassall, the heroic GP protagonist of 'A Fortunate Man'?

Was he a desirable role model?

Like many of the doctors I see in my practitioner health service,
being a doctor meant everything to him.

So much so, he blurred the boundaries between his professional and his personal life, creating a hybrid identity – an amalgam of these two personae, which I call the ‘medical self’ – a single identity.

This **medical self** – the merging of the professional and personal – could be thought of as the essence of vocation.

As one doctor attending my service told me:

“being a medic is not just a job that you go to, it is something you are.

I can no more take the doctor out of me than an artist can take their creativity out of them.

And I believe that it is this medical self, which acts, during our work, to mask our suffering, and protects us from subjective feelings of guilt, fear and hopelessness.

But this can, and often does, get out of hand, especially when not counterbalanced by a healthy working environment or personal support.

Sassall, like so many doctors, attending my service, defined himself by his work.

When his long-term practice partner died, instead of acquiring a new one, he chose to split the list and instead run the practice single-handedly.

Berger’s book even describes how Sassall longed to be woken at night to do house calls!

He was incapable of doing nothing – and just being.

Put simply, Sassall was a workaholic.

He also suffered from regular bouts of depression which affected his ability to do his job properly.

At one point in the book, Berger even questions Sassall’s fitness to practice.

Sadly, after the death of his wife, things became too much for Sassall, and eventually he took his own life.

Which brings me to the subject of mental illness in doctors.

In recent years, as I have said, much of my time has been taken up with running the practitioner health service.

Initially only for doctors working in London, the service has now been extended to cover all GPs and GP trainees in England², meaning that over 85,000 doctors can now access it – and around 1,000 do so each year.

That it exists at all, is an acknowledgement by NHS England that doctors, and, in particular GPs, matter.

It's unique in that it's run by a GP – me, leading a national network of over 100 psychiatrists, mental health nurses, GPs and therapists.

Doctors refer themselves and we, in turn, give them the gift of time,
a confidential space,
and care to get better.

And once in treatment, our patients have remarkably good outcomes.

Nearly 80% of those with addiction are abstinent after 6 months of treatment – and this remains the case even 5 years later.

For all patients, improvements are substantial in areas of mental health, social functioning, numbers returning to work or training,
and a reduction in the involvement of the regulator.

It's a very successful programme.

But....

Across all age ranges

In all health systems

private or public....

In all countries

And across all specialties

² www.gphealthservice.nhs.uk

It turns out doctors have higher rates of mental illness than an aged-matched population.

And the rate is increasing.

There are **many reasons for this** – let's look at some of them.

From our first day at medical school we become different – even special – and begin to connect with the family of medicine, past and present.

And our specialness is reinforced during training, as the distance between us and our non-medical peers widens.

Something that's inevitable, considering our more onerous and longer training.

As doctors, we learn,

play,

work,

live,

and even love together –

many of us form life-long relationships with other doctors – myself included.

As we train, doctors learn a new scientific language.

And symbolically our new medical identity is reinforced through dress – the white coat (albeit worn less and less), and especially through the acquisition of the new title - “Doctor”.

With its strict hierarchies, expectations around behaviour – in and out of work –

and professional solidarity,

medicine sets us apart from others.

And in the process, our medical self –

that coalition of our professional and personal identities – becomes enmeshed in the *group of belonging* that is medicine.

The connections formed by this group are vital if we are to survive a lifetime exposed to death, despair and disability.

They protect us,
support us
and sustain us.

The group also determines its own norms – which in turn dictate certain behaviours.

Amongst these norms, is the idea that we do not become sick.

It is patients, on the other side of the consulting room, or the other side of the needle who become unwell – not doctors.³

Which explains, in part, why it's so difficult for a doctor to take on the patient role when they're unwell.

In his posthumous memoir, *When Breath Becomes Air*, the neurosurgeon, Paul Kalanithi, wonders:

*“Why was I so authoritative in a surgeon’s coat,
but so meek in a patient’s gown?”*

It is because as the complete object – the ‘doctor’ – we create an aura of invincibility around ourselves.

*“We wear magic white coats...
we destroy disease all the time: how can it attack us?”*

We're simply not good at being patients ourselves.

There are other reasons why we are at risk.

³ “the patient is the one with the disease” (Luhmann, 2000:90).

Doctors occupy a privileged position in society.

We have status, expertise and considerable power –
though less than in Pickles' day.

We're granted access to the most intimate and secret parts of our patients' lives.

But with these privileges come darker consequences.

Patients confide in us.

They tell us things they wouldn't tell anyone else –
not even their closest friends or family.

This can be a tremendous burden for us.

We enter 'the swampy lowland' with our patients –
a place of confusing 'messes' incapable of technical solution,
as Donald Shon describes it.

To survive a life in medicine, we develop strategies to

suppress our emotions by

shoring up our psychological defences.

But these defences do not buy us psychological immunity.

Ironically, the personality traits which make us good doctors –

obsessiveness,

perfectionism,

even narcissism –

can, when our backs are against the wall,

turn into the compulsive triad of

doubt,

guilt,

and an exaggerated sense of responsibility.

On top of this, there is also the huge weight of expectation laid on us by the politicians and policy-makers, especially for GPs – who are seen both as the saviour and scapegoat of the NHS.

Despite ever-dwindling resources – and constant reorganisations – our political masters act as though we can somehow magically

protect the public from illness, and even death.

The response of many of us to impossible challenges like these,
is to do what we have been trained to do –
push ourselves even harder
risking burn-out and mental illness.

There is a sense, though, that the increase we are seeing
in mental illness amongst doctors today,
is due to the current generation being less resilient than previous ones –
of somehow lacking the required ‘stiff upper lip.’

What I do know and have learnt from evidence and experience
is that doctors, past and present,
are amongst the most resilient individuals in society.
We can go long hours without sleep, food, bathroom breaks –
we even have resilient bladders.
Given the right support, doctors survive and thrive in the face of adversity.

Resilience is about bending with pressure and bouncing back.
But given the wrong circumstances,
each one of us has our breaking point –
beyond which we can go no further.

And it was always thus...

Earlier at my home this year we had a flood in our basement.
As I was clearing up the mess, I came across an old Maudsely Gazette.
I flicked through the pages, wondering why I'd kept it,
and found an article I'd written in the summer of 1989.
At that time, I had switched from psychiatry to general practice,
which meant spending six months in obstetrics and gynaecology
as a junior hospital doctor.

The article described my experience of those six months.

Looking back, before I read the article, my memories of this period had been happy ones – of the comradeship between colleagues, and fun at work.

Or so I thought.

The article was called “Lest We Forget”, and in the centre of it was a photo of four junior doctors – myself and three others.

The caption beneath the photo read:

‘Juniors launch fund to fight hours’ case in court’.

One of us – [Dr] Chris Johnstone – was suing his health authority over excessive duty hours, and he needed to raise £20,000 to take the case to court – an early form of crowdsourcing.

In the piece, I described my shock at working such long hours.

I wrote of the unremitting nights on call, and their devastating impact on myself and my colleagues.

We couldn’t sleep.

We couldn’t concentrate.

We found little to enjoy in life.

And, like many of my peers at the time,

I blamed myself for not being able to cope.

I wrote:

“for the first time, I understood the process where junior doctors could become so depressed as to take their own lives, sometimes performing the act in their own on-call room.”

I was deeply shocked to see that I’d written this,

and reading it reminded me how important it is that we face up

to the reality of the past,

and not gloss over the bits that caused us pain.

I believe the rise in mental distress amongst doctors is made worse by the older generation – my generation –

clinging to a distorted view
of a golden past that never was.

A mythologised past places an enormous burden of unrealistic expectations on the shoulders of the current generation of GPs.

My generation reminisce about continuity of care, partnerships
and the freedom to do what we felt was right for patients – unconstrained by the demands of a marketised health care system.

And it's true – it was like that.

But what we don't mention was the paternalism, or the patronage.

You got on largely by who you knew, not what you knew.

We don't mention the bullying, the long hours,
and how – as junior [partners] doctors – we were left unsupported,
expected to do most of the work on our own.

I worry that many [young] GPs make a valiant, but futile, effort
to live up to an impossible standard,
measuring themselves against medical heroes – like Pickles and Sassall –who, on closer inspection,
are revealed to have feet of clay.

Facing up to the realities of our profession's past helps us see
that those who came before us were no better,
and no worse,
than we are today.

Today, as our workload grows heavier
and its complexity and intensity increases,
it's all too easy to feel that general practice is in crisis.
But if you look back over the history of our profession,
as I have done,

it's clear that GPs have often found themselves trying to do their best against a background of cuts and disruptive reorganisations.

Through the generations, the profession has adapted.

And this is what we are doing, **now, today**.

For example,

Recently, like many of you,

I've had to move around and consult with strangers,

with patients I will only meet once.

I was recently asked to work in a practice I had never worked in before.

The resident GP had gone off sick at short notice and I was asked to cover his evening surgery.

It was already getting dark when I arrived at the practice.

It had been pouring with rain.

I was cold and I was wet – but strangely excited.

I knew that the tools of my trade were in me.

I was confident that despite never having worked in this practice,

and never having met any of the patients or staff,

I would know what to do.

Over the next four hours, I weaved in and out of strangers' lives.

I listened to their stories of distress;

a bereavement;

and joy: a woman becoming pregnant after years of infertility.

I reassured the young that their symptoms were normal

and saw the old, and the very old.

I consulted with patients, face-to-face,

on the phone, and via the web.

I didn't just cope or survive,

I thrived – as the next generation, will too.

At the end of my shift I experienced the profound satisfaction and joy of a job well done.

As I engaged with each individual patient

I felt as if I'd known them, their families and communities,
For all my life.

During our brief encounters,
they had made as much difference to me,
as I hope I had to them.

Pickles, Sassall and my father lived where they worked,
and stayed put for most of their working lives.

The relationships they built with their patients were often life-long.

For much of my working life, the same could be said of me too.

But, it will **not** be the same for the next generation.

Today, people are more mobile,
and spend more of their lives in the virtual world,
expecting instant and round-the-clock services.

The New Kind of Doctor will have to be trained to adapt to these changing expectations.

Not with the three years' training we have now, or even four years, which was agreed when I was
your Chair,

but, I hope, five years.

Because...extended training will bring more opportunities and increased confidence for tomorrow's
doctors.

The job I started out in 35 years ago is very different today –

of course it is!

These days it is faster,

more litigious,

and more regulated.

But it is also safer, more equal and more varied,

and offers young doctors [general practitioners] far more opportunities.

And it may surprise you when I say that –

despite the difficulties we currently face –

I believe there's never been a more exciting time to be a GP.

Your future will be one where the relationship between doctors and patients is more equal.

One in which patients are more involved

But they must also be more responsible for their own health.

Social media will play an ever-greater part in the way doctors and patients communicate –

creating a less formal, more democratised relationship involving

new ways of delivering care –

via Tweet-Deck and Crowd med, for example.

Genomics will take off,

heralding the era of truly personalised medicine.

The New Kind of Doctor will have to learn how to decipher and translate this information for patients –

something we GPs, with our ability to manage risk,

deal with uncertainty,

and care for our patients holistically – are skilled at.

The digital revolution will mean increasing numbers of consultations,

will be virtual, as mine are,

or involve artificial intelligence.

Our challenge will be to ensure this becomes our servant,

not our master.

These are just a few of the momentous changes we're already

coming to terms with –

and there will be many more that we can't even anticipate.

But, if we are going to prevail in the shifting sands of the future,

doctors will have to challenge some of the assumptions that we –

the older generation –

have made on their behalf.

We teach doctors to make the patient their first concern.

Indeed, this is first on the General Medical Council's list of the duties of a doctor.

And further, the Geneva Declaration –

which doctors now sign up to when they enter the profession – begins with the solemn pledge to:

“consecrate my life to the service of humanity⁴”.

Of course, doctors should always act honestly, compassionately and avoid conflicts of interest –

but is it reasonable to ask newly qualified doctors to consecrate their life to the service of humanity?

It's a very big ask.

[pause]

I spoke before about my dad, Sassal and Pickles,

who typified the myth of the saintly self-sacrificing doctor,

I believe this image is getting in the way, and in danger of damaging the next generation of doctors.

We need a new definition of vocation, adapted to the times we live in. One that reflects the fact that we are all human beings trying to do the best for our patients.

I talked earlier about the medical self being

enmeshed in our 'group of belonging',

and how important these spaces and connections are.

But they are in serious danger of disappearing.

Spaces such as the team, the Firm, the doctors mess.

The new kind of doctor must create their own new spaces and connections if they are to survive a lifetime in practice.

⁴ <http://www.wma.net/en/30publications/10policies/g1/>

If we expect doctors to give their all to others
then the quid pro quo is that we have to protect the doctor –
and the connections which sustain them.

I think this means recreating their *groups of belonging*.

Protected spaces where they can learn, cry, suffer – and celebrate – together – free from the clutter of
inspection, assessment or monitoring.

My work with sick doctors has taught me an important lesson.

To survive a lifetime in the fast and furious world of modern health care it's vitally important that we
take proper care of ourselves.

This is not about denying the needs of the patient.

But self-sacrifice is no longer an option.

It's bad for doctors.

And what's bad for doctors is bad for patients too.

Making that extra visit – or seeing that extra patient – is fine in a crisis, but, when the system
demands too much,

the doctors of the future must be encouraged to say, “no more!”.

The new kind of doctor must think about their own needs if
they're going to be able to do their best for patients.

The new kind of doctor must expect to be trained,
and to work,

in an environment where the demands placed on them
do not make them unwell.

And when we **do** become unwell,

it's no longer acceptable to blame us,

and to patch us up and send us back to the battlefield,

expecting us to just get on with it!

Looking after doctors with mental health problems has shown me a different side to medicine.

And although it can be upsetting to face up to the reality of the suffering some doctors go through,
it's also inspiring to watch as they come through it,
and recover,
and return to health and back to work,
as most of my patients do.

The myths of our profession do little to help those who
find themselves in turmoil.

In truth, they make things worse by promoting unrealistic expectations of what a 'good' doctor
should be.

Of course we must take the best of the past
but we can only move our profession forward by looking to the future.

It's time for us to tell and share stories that reflect the reality of our profession, both good and bad.
And it's time for us to tell stories that look forward to a challenging and exciting future –
not ones that hark back to a golden age that never was.

Thank you.

Clare Gerada