A view from the edge: professionalism in an island practice

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Last Saturday night was interesting. One of our expectant mothers had a sudden and massive haemorrhage at 32 weeks and 1.30am. With two more births due at any time our midwife couldn't leave the islands, and so an hour later—with two large bore intravenous cannulae pouring fluids into her veins—I found myself in the back of a Royal Navy Air Sea Rescue helicopter, feeling the woman's pulse and forehead and listening to the laconic conversation of the pilot, navigator, and ground control as they flew us through the clouds and mist and up the River Fal from Falmouth to Truro: *"I'm just going to swing a little right here after the trees ... Look out round this bend, there was a tall ship moored here when I was over last week ... Mind the power lines, maximum height 220ft ... Should be a red light at 11 O'clock ... I have visual..."* As we approached the landing pad at the hospital the crew member in the back slid open the side door, and, sitting half in and half out of the aircraft, shone a powerful torch towards the ground and gave the pilot instructions for the last hundred metres' descent.

We bundled into the waiting ambulance, and were in a labour room five minutes later. After what seemed far too long but was probably about three minutes the obstetric registrar walked in, assessed the situation in a few seconds, and ordered anaesthetist, paediatrician, four units of blood, and immediate transfer to theatre. The father was shepherded into a recovery room, fearing the worst, but they let me—also fearing the worst—stay and watch the quickest and slickest caesarean section I've ever seen. Out came the baby, surprisingly pink, and after about a minute and a sniff of oxygen, in went its first breath and out came its first cry: miraculous!

It being a Sunday morning I was stranded on the mainland until Monday. So while I idled around a damp and grey Penzance, back on the islands my partner had to take over, as second-on, and found himself attending two deliveries (both normal, thank goodness), accompanying the police to collect a manic patient from an off-island, and doing a chemical cardioversion on someone with sudden onset atrial fibrillation. Some weekend ...

I am not going to pretend that this extract from my diary was a typical weekend—in fact, if that were the case I would have fled back to the mainland long ago—but it does give a flavour of what makes island medicine rather different. It raises a number of issues of the nature of professionalism which I shall attempt to explore. Before doing so, however, let me give a very brief picture of our practice and its setting.

The Isles of Scilly lie about 25 miles southwest of Land's End, and consist of five inhabited islands—St Mary's, Treco, St Martin's, Bryher, and St Agnes—with a resident population of just over 2300. The population reaches a peak of 5500 in the summer holidays with the influx of tourists and

seasonal workers to service them. We register over 1000 temporary residents each year.

Our practice has two full time partners and an assistant GP who joins us from March through to October. We work in a newly built health centre with spectacular views; next door is the 12 bedded Community Hospital, complete with a minor injuries unit, a delivery room, and a palliative care suite

We have an x ray facility, but it is nowadays available for use only by qualified radiographers, one of whom flies over once a week. Most suspected fractures have to be flown out to the mainland for definitive diagnosis and treatment.

We inevitably do all our out-of-hours care, as well as supporting the hospital nursing staff and midwife. Immediate care is co-ordinated by our resident ambulance technician, and on the smaller, so called "off-islands" there are volunteer first responders trained in resuscitation and first aid. The islands recently took delivery of a brand new water ambulance, the first of its kind in the UK, which allows rapid and safe transfer of casualties from the off-islands to St Mary's, or even, in fog-bound extremis, to Penzance.

I started working on the Isles of Scilly in 2001, having spent the previous 13 years in a small practice that I had established in a housing estate on the edge of Salisbury, southern England. For many of those years we had spent family holidays on the Scillies, and I had often fantasised about working there as a doctor. The chance to turn that dream into reality came quite out of the blue, and I jumped at it.

Three years on, I have never been so content in my work. And although this has much to do with living in a fabulous natural environment and being blessed with a happy home life, it also has to do with the nature of the work itself, a sense of fulfilment, and a conviction that it is a job worth doing. In short, it has to do with professional satisfaction. But this obviously begs the question of what professionalism means in medicine. I see it as embodying three core values: competence, commitment, and compassion.

COMPETENCE

Firstly, competence. By this I mean a body of skills and knowledge that enables us to do the tasks required. This is self-evidently a necessary value in any profession. I have always believed that experience is the best path to increased competence, and I have increased my own skills and knowledge in meeting the challenges of the past three years. I have attended courses on emergency care, obstetrics, and palliative care, but most of my learning is done on the job and with the help of those I work with. I know that my competencies will be judged not only by my patients but also by my professional colleagues.

Awareness of the limits to one's competence is essential, a lesson I learnt the hard way when I tried to insert my first suprapubic catheter. The unfortunate patient was an octogenarian, retired air-force officer who swore that the experience was worse than any of his war wounds. The very nature of island practice, where word soon gets around about both weaknesses and strengths, is a strong incentive towards

Figure 1 Sea King helicopter from RN Culdrose at St Mary's airport.

maintaining and improving competence—far more potent than any Professional Learning Plan or annual appraisal.

10 August 2001

At 1.30am a woman arrived at the hospital with severe pain in her side, a trace of blood in her urine, and, being a diabetic, a very high blood sugar. I thought she must have renal colic, and a shot of pethidine calmed the pain down to a tolerable level, but the blood sugar was a worry. It's about fifteen years since I've had to deal with an acutely ill diabetic in hospital, so I reached for the medical textbook on the hospital shelf, only to find it had been published a quarter of a century ago, and I couldn't even make sense of the units. I found a more up to date textbook in the health centre next door, with the requisite recipe in it. Having set up a drip of saline and dextrose, and instructions for intermittent doses of insulin to be given depending on the blood sugar levels, I went back to bed. Two hours later my long-awaited drift back to sleep was interrupted, with the ruthless timing of a seasoned torturer, by a phone call from the nurse on duty asking if she should now give the insulin as per my written instructions? [...] We flew [the patient] out to the Royal Cornwall Hospital in Truro on the Air Ambulance early in the morning, and by the afternoon she was recovering from a nephrectomy for a benign renal tumour.

I learnt a lot that night, as I did when I did my first thrombolysis, gave intravenous adenosine for an SVT, and dealt with a case of status epilepticus (not all on the same patient, I hasten to add). The epileptic case reinforces the importance of knowing when things are slipping beyond your competence; it also illustrates another essential GP skill.

2 November 2003

A man was brought in who had been having a series of seizures for a couple of hours. He continued to do so despite maximum doses of intravenous diazepam. The next drug in my book had the warning "should only be given where full intensive care facilities are available, because of the risk of cardiac arrest and respiratory depression". Hmmm ... Thinking an expert opinion might help, I rang the duty medical registrar.

Medical registrar: "I think you need to fly him over as soon as possible, but I think you should speak to a neurologist". Easier said than done:

Switchboard at Truro: "I'll put you though to the SHO, he'll know which consultant is on duty ..."

Figure 2 The new water ambulance off Tresco.

SHO: "There aren't any consultants here, I'll put you back to switchboard, they'll know where they are ..."

Switchboard: "I've spoken to the secretary. They're in a meeting. I'll put you through to her ..."

Secretary: "Both the consultants are at a meeting in Portsmouth, I'll give you the number ..."

Portsmouth postgraduate centre switchboard: "No one's here, the meeting's just finished. I'll just go and see if I can find anyone ... No, sorry. I'll give you the main switchboard's number, they'll find someone for you ..."

Portsmouth main switchboard: "I'll try the Registrar for you ..."

Neurology registrar: "You should definitely fly him out, and here's what you should do in the meantime ..." Hallelujah!

The patient is fine now. We have a medical student attached to the practice for four weeks, and my first piece of advice to him was this: one of the essential competencies of being a GP is to stay calm while using the telephone ...

Figure 3 Resuscitator in the labour ward: competence in its use is expected!

Another of the essential competencies is to know your limitations.

COMMITMENT

This second core value encompasses commitment to the job, to one's colleagues, and to one's patients. Again, the very visibility of being one of the resident doctors on the islands makes commitment inescapable. We are on call one shift in two through the winter, and one in three in the summer, and one of us is always contactable as the reserve doctor in case of a crisis. Patients rarely abuse our availability, so the majority of out-of-hours calls demand a response. Reluctance to accept a request for a home visit would rapidly become common knowledge, and failure to respond to calls from the hospital would not impress the nursing staff.

But these are the external factors that encourage commitment. I hope that just as important is the *internal* motivation that comes from a sense of belonging to the community among whom I work. Furthermore, it is much easier to remain committed to a job that one enjoys. One of the pleasures of our practice is doing the regular branch surgeries on the off-islands—even in winter.

6 February 2002

I drive down to the quay and board the medical launch along with Rick (the islands' only vet), Di (the health visitor), and Kerry (the midwife). Martin the coxswain has his dog Scout aboard, and Di brings hers too. The biting easterly wind keeps us all inside the cabin, but spray from the breaking waves leaks through all the windows and the floor is awash. On the way we listen to the coastguard broadcasts for the area: "Strong to gale force winds, easterly; sea conditions, rough". Spot on, we all agree. Rick, Di, and I disembark at Tresco, and Martin takes Kerry on to St Martin's for a postnatal visit to the islands' latest mother.

Di and I walk the short distance to the community centre where she visits the preschool children at the lively playgroup, and I see my eight patients in the room shared (but not at the same time) by the adult learning/IT centre. One 'DNA'—he never remembers, despite being on Warfarin and needing regular blood tests—three coughs and colds, two contraceptive checks, and a rectal problem you don't want to hear about.

The winter surgeries are short, there being few visitors and the main hotel being closed, so I pack up my things and

Figure 4 The author arriving for branch surgery on St Agnes: commitment or a nice day out?

walk over the hill to the New Inn, which is empty, warm, and welcoming. After lunch, Martin ferries us across to Bryher. I decide to do some home visits to save some of my patients from having to go out on such a nasty day. First port of call is a bungalow where I take a sample of blood from one of the ever-growing number of elderly people on Warfarin for their fibrillating hearts; she rings through to the next one to tell him I'm on my way. He, fibrillating too, takes a minute or two off from serving behind the counter of his shop while I take his blood in the kitchen, grateful for the warmth of the Aga. From there it's a warming walk up the concrete road to visit Jackie, a Scillonian farmer with heart disease and diabetes who denies he has either.

"I've come to take a drop of blood, Jackie."

"Arr, well I've cancelled that, 'cos I've just been eating, see." I do see: a big plate of fried potato hash, just what the dietician *didn't* order.

"It doesn't matter for this blood test. You're still taking those tablets we started for your diabetes aren't you?"

"Oh no, doc, I thought they was just a one-off, like, I didn't know you wanted me to keep taking them."

"Yep, three times a day, with meals."

"Well there's my problem, doc. You see I often eat out at lunch, and I can't seem to remember to take tablets in the evening, look ..."

And so it goes; it used to be called "problems with patient compliance"; that was deemed too judgmental of patients, who are now partners in care and not recipients of care, and it has been renamed "problems with concordance". Fair enough. For sure, Jackie's and my views on the meaning, treatment, and implications of diabetes are far from concordant. We'd better both try harder.

I call in too at the cottage of Charlie, who had his appendix removed last week after I admitted him to the hospital at 2am. He had signs of peritonitis, but still smarting from the management's criticism of our extravagance with emergency fly-outs by the Royal Navy at £7000 a go, I had kept him overnight and my partner had arranged his evacuation by Cornwall Air Ambulance, a snip at only £2000, the next morning. Should I have sent him out earlier? Charlie said, "When they opened me up there was bits of my appendix floating around, shot to pieces it was." But when I had rung the SHO in the night he had said they wouldn't operate till daytime anyway. All's well that ends well.

With days like that, commitment comes easily. This isn't inner city medical practice behind a security fence, with hypodermic needles in the car park. But even in our comfortable environment where three storeys count as a tower block and bicycle theft a major crime, commitment has to have its limits if it is not to lead to exhaustion and burnout. We try to balance our relatively heavy on-call duties with half days and three day weekends, and when I am not at work I do my best to look extremely unprofessional in public: easy enough in a wetsuit, or shorts and T-shirt. Generally our patients respect the boundaries: only once have I been asked to look at a leg ulcer in the aisle of the Co-op.

COMPASSION

We often feel awkward talking about compassion, afraid perhaps of sounding self-righteous and slightly pompous. We prefer to aim for "empathy", subtly different in meaning. Yet without compassion we are failing to practise good medicine. I make no special claim to compassion, but I know, better than I have done in the past, just how important a value it is.

Once again, this stems partly from the features of a small community where, as I have already said, word gets around.

It is a curious fact that, of the occasional bits of positive feedback I have received, the one that has been repeated to me more than once related to my helping an elderly woman with terminal cancer to arrange a living will. I downloaded a proforma from the BMA website, modified it a little to suit her circumstances, and took it down to her house to read it through and complete it. Never mind her non-functioning right lung, her anorexia, or her pain: the one thing she wanted was relief of her anxiety over the possibility of having her life artificially prolonged. Thankfully, she died in our hospital a few months later, peacefully and with great dignity, with minimal interference. It is humbling to have one's praises sung for doing something, on the face of it, so small; humbling too to be reminded that many people are much more anxious about *receiving* medical intervention than being denied it.

Sometimes compassion is all we can offer, as was the case here:

12 September 2002

What do you say to a man who lost his wife to cancer—at a relatively young age—a month ago, and is weeping day and night? Who wakes at 4am, puts on his oilskins and walks down to the graveyard to lie by her grave? Who feels that her soul—or whatever it is, if there is such a thing—hasn't yet gone to wherever it should go to find peace? Who doesn't want me to write this stuff down on his records in case he's thought mad and is "put away"? He's as unreligious as I am, but when I suggested that maybe she couldn't leave because he wouldn't let her, he became thoughtful and wondered if this might be true. I suppose I was speaking metaphorically, but then perhaps he was too. What struck me most about the conversation we had—apart from his terrible distress—was how confused I felt about how to respond. I'm well accustomed to this feeling of not knowing what direction to take with a patient, but thankfully, as on this occasion, the outcome is often more positive than I expect at the outset. As E M Forster put it, "Only connect".

As with competence and commitment, I suppose there have to be limits to compassion. It is certainly important to try to preserve some emotional distance between oneself and one's patients, and in a small community this is sometimes difficult. All my friends and colleagues are, potentially at least, my patients, and for all of us there is an inevitable blurring of boundaries on occasion. The other side of this, though, is that our close relationships encourage mutual support and comfort in difficult times.

CONCLUSION

I have considered, and illustrated from my own experiences, three core professional values of competence, commitment, and compassion. But the title of this short essay is "A view from the edge", a phrase with two interpretations. Firstly, we live and work physically "on the edge".

The remoteness and relative isolation of our islands give us greater autonomy and responsibility than is often possible on the mainland. Our intimate knowledge of our resident population too encourages a degree of trust that is more difficult to foster in a larger or more amorphous population. Autonomy and trust are precious resources that encourage commitment, and both need to be defended.

Secondly, British general medical practitioners are "on the edge" in the sense of launching into the uncharted and stormy waters (forgive yet another nautical metaphor) of a

Figure 5 Stormy waters ...

new service contract that has wide ranging ramifications in our professional lives. I am not concerned here to argue all the pros and cons of the contract, but I do have grave concerns about some of its implications.

By reducing much of our day to day clinical work to ticking computerised checklists and chasing numerous targets—some of dubious validity and soon to be followed by many more—we risk over-medicalisation of daily life; over-simplification of complex tasks; neglect of what cannot be computerised or measured; a narrowing of our traditional roles, and damage to our competence as generalists. By breaking up general practice into routine and out-of-hours care, by dividing our work into core and additional services with separate contracts for every service, and by doing away with personal lists, we risk undermining our personal commitment to our patients and our practices.

And by increasing our exposure to centralised control, external audit, regulation, and bureaucracy—all those things that Willis' ² has addressed in his writings—we risk squeezing out our capacity for compassion as well.

Teachers have become enslaved by a similar system, and as a result their professionalism has been devalued and distorted, and their morale shattered. We must fight to maintain the necessary autonomy for our professional values to flourish if we are to escape the same fate.

I will end on a very personal note. Last summer my own mother was nursed and died in the terminal care suite at St Mary's hospital.

5 October 2003

Just after 3am a nurse rang us to say [my mother's] breathing had become weaker, and I went straight back to the hospital, just in time. My wife and I were holding her hand as her final breaths came with steadily diminishing volume and frequency, like a stuttering candle exhausting its receding pool of wax. My sister and brother-in-law joined us a few minutes later, and we sat together in the embracing warmth and strength of Mary's personality, sustained too by the miraculous kindness of the two nurses who had steered her and us through the final hours.

Through the French windows we could see the dark line of Gugh and Agnes on the horizon, lit by a yellow half moon. The buoy marking the Spanish Ledges flashed to the south, its bell clanging mournfully. To the southwest the lume of Bishop Rock lighthouse beamed upwards over the silhouette of the Garrison, keeping living souls safe at sea even as this one took flight.

Throughout my mother's demise I witnessed at first hand the work of my medical and nursing colleagues, and what I observed was the exercise of competence, commitment, and compassion. They did, in short, a professional job: long may they, and all of us, be allowed to do so.

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All excerpts are from the author's unpublished personal diary. It was written in part for a lay audience of family and friends. Details of individual cases have been disguised to reduce their likelihood of

identification; the patients concerned have read the excerpts and agreed to their publication in this form.

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