RACGP

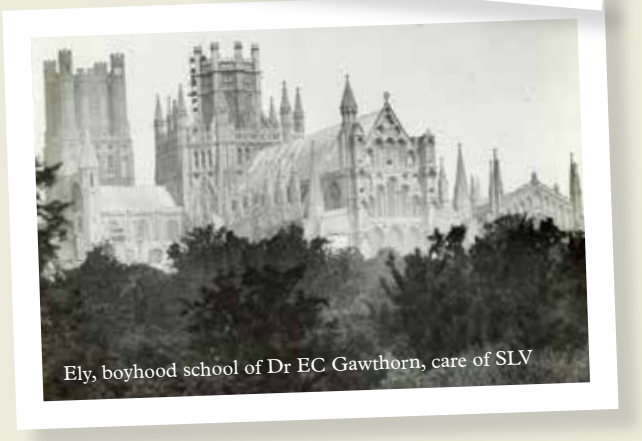
Why and how I became a general practitioner

– and other observations by Edward Charles Ted Gawthorn


Dr EC 'Ted' Gawthorn

Part 1: before graduation

Thanks to my parents' sacrifices I was privileged to attend, as a boarder, one of the oldest public schools in England called Ely. It was founded by St Etheldreda in 670 AD on a high hill just north of Cambridge overlooking miles of flat fenland country.


Ely, boyhood school of Dr EC Gawthorn, care of SLV

St. Etheldreda's name was shortened to St Audrey; hence the word 'tawdry' from the cheap bric-a-brac, which was sold at the local fair. And it was probably a tawdry assortment of boys who entered school in my year of 1934, to emerge into Adolf Hitler's war in 1940 as well disciplined bright young athletes ideal for 'officer-like qualities' and fodder for the blitzkrieg at the time when our better equipped enemy was winning.

Perhaps one of the saddest moments of my life was after the war when the memorial at school was unveiled. It read, with some exceptions, like my class register. Together, with a smattering of the names of some of the masters who had taught us. They were called masters not teachers in those days and discipline was strict but fair.

Struck by the beauty of the cathedral and the sanctity of its surroundings, my earliest adolescent ambition was for the priesthood. But later in the fifth and sixth forms this was replaced. Under the influence of my uncle and with much talk of impending war, my mind was irrevocably changed to becoming a regular naval officer. A visit to Dartmouth sealed the issue, and perhaps that was just as well. My distinctions were in mathematics, physics and chemistry, and to my detriment only a weak pass in Latin and the humanities, which was hardly satisfactory embryonic material for a priest.

Then war struck and there was the youthful excitement of 'Hanging up the washing on the Siegfried Line', and 'What a surprise for Il Duce' and all that. It seemed that our enemy was providing me an ideal opportunity of a naval career, but not so the British government. Hoare

A Royal Navy Air Fleet 'Seafire' plane care of AWM

Belisha (of Belisha beacon fame) was now minister for war, and the policy was no commissions except through the ranks. The navy, therefore, offered me a second-best opportunity to train as a fleet air arm pilot and short service (hostilities only) RNVR commission. Disappointed, I accepted this, setting the scene, assuming survival, for the opportunity at war's end to leave the navy for something really worthwhile.

The navy taught me leadership, concluding at 23 years of age in command of a squadron of 14 assorted aircraft – a kind of general practice – with 10 officers, 60 naval ratings and 50 Wrens. Bless them. Quite a family, with all its little day-to-day problems. It also taught me survival and rapid decision-making.

A deck landing on an escort carrier (commonly called Woolworths) in an Atlantic gale with a delicate aircraft such as the Seafire (Sea Spitfire) is a daunting business. The wingspan was 32 feet, the flight deck 50 feet wide. On one occasion I ended in the Atlantic, rather than on the carrier, and that led to my first real acquaintance with the medical profession at the receiving end in hospital.

There were other occasions too: an appendectomy, and nasal surgery to fix my sinuses. On the last of these times I met her. She was a naval nurse called Betty and eight months later we were married. London was in the grip of V1 'buzz bombs' and V2 rockets at the time, and her father was a general practitioner in the western suburbs.

It was a delight to accompany him on rounds, and his patients enjoyed being introduced to a young man with such a nice uniform and pilots wings.

Almost abruptly the war ended, and we suddenly found ourselves with the stark reality that civil life had no need for any crash hot people whose only qualification was flying and looking after the Wrens. And with my nursing wife and medical father-in-law, the decision was not too difficult. But as a mature-age student with family responsibilities with the arrival of a baby boy, the prospect of descending from the lofty responsibilities of officer rank to the lowest form of life a first-year medical student required considerable adjustment.

Ours was an interesting year at Bristol. With so many university places being saved for ex-service people, the other 25 per cent seemed very young, but were ever so bright.

Unlike the usual blast cell type of medical student, we deliberately trained ourselves as undergraduates for general practice. On graduation, I was 30 years of age and with a family and just had no time, in spite of distinctions in finals, to hang around hospitals on the pittance that residents were paid in those days.

Four pounds per week with three pounds 50 pence deducted for keep, left only fifteen shillings for the family. General practice it had to be. So during our undergraduate years we learned the important things, and sought keenly as much practical experience as possible. In sixth year we even dressed to look like doctors and I still possess the leather bag in which I carried my own instruments. Very impressive in finals!

But again the British government got in our way. The National Health Service was in full swing and it meant that our generation could get a job as a poorly paid sweated assistant, but you got sacked if you dared to mention a partnership to your employer. So as effectively as the last century's transportation of criminals populated Australia, the British Health Service sent us in droves to this country. I was one of the first of my year to arrive – raw and green – and of the 26 people who graduated with me, I have seen 16 in Melbourne. A number of these are suburban general practitioners like me.

Part 2: after graduation

Circumstances threw us in at the deep end of general practice. Before leaving England, I did a locum and was shocked to find 60 patients in the morning surgery, a string of calls for trivia, and another 60 in the afternoon. But it was simpler. Most of the patients needed to come for some technical reason, such as a prescription or certificate, and the British health system positively encouraged referral to hospital for patients with significant problems.

After those stresses, it was a rest cure for me to work my way here as a ship's surgeon on one of Vestey's Blue Star vessels. Had it been 1987 when contracts were less viable, I would have stayed in Perth with its relaxed beauty, rather than fulfilling my obligation to come to Melbourne. The deal in Melbourne fell through anyway. However, they wanted somebody for 2 weeks in Brunswick, and I took the job and they invited me to stay. That was 35 years ago. On 30 November 1987, I retired and for reasons later apparent, we returned to Perth to live.

So, in the days before FMP and chairs of community medicine, what did you do about learning general practice and continuing medical education? And especially when you find yourself in a strange country where they don't quite speak the same language.

There are many different pathways you could take. Some did not bother. Others became too busy where doctors were in short supply to do anything other than learn by experience. Of course, we must concede that experience is the most important component of CME, but it should never be the only factor.

Caring, honesty and an attitude of service in addition to experience have multiplying effects towards good practice. The opposite is also true. Those who do not care, or who are obsessed with reward have little chance of achieving quality of care.

Assuming experience and correct attitude, my own recipe for continuing education is described below together with some other details of my history that influenced this process.

Group practice

Membership of a good, well-motivated group is almost an essential element of continuing education when experience is lacking. My thanks are due to my senior partners, the late Ken Rattan, and my good friend Keith Smyth for providing so many corridor consultations and so much helpful advice and resource on clinical problems. And the patients do appreciate it when extra interest is shown in their problems. A group should be organised to allow for conference time in a relaxed atmosphere where issues can be discussed in depth.

By a natural process, not in a similar manner to Alec Guinness in his film *Kind Hearts and Coronets*, I became senior partner 12 years ago. It has been my privilege to try to accord to the other five, who will soon be without me, the same kind of patient management guidance that I received. And it will be with much sorrow that I depart from this happy association.

The formula of equality and democracy in a partnership is not always easy to achieve. It depends on the personalities involved, and on everybody's willingness to put in a little more than they take out. This also applies to practice staff, and gentleness and quietness will enable the patients to feel relaxed and welcome in a family setting. In the same way as a placid well-adjusted mother will generally have a happy child; patients will react favourably to absence of stress and harmony. This harmonious and caring situation will naturally lead to continuation and updating of professional education.

The fostering of correct relationships with consultants and patients

To use every referral as an exercise in CME is easy and of great benefit to both the GP and their patient. To present the case as a repeat of case reports in medical finals and to read the consultant's report with critical objectivity is valuable. Occasionally, we should take the trouble and have courage to phone the consultant if there is anything in the report that is not understood or that you disagree with. It keeps them on their toes too. I nearly always involve patients in this process of summarising by reading to them the report and inviting discussion. It is their life, they have a right to know.

It is my habit to never read an X-ray report without looking at the films first. This is generally done in the patient's presence and a useful opportunity can be taken to demonstrate both the normal anatomy and their problem. It is surprising that you often find something not in the report. It must be awfully trying for radiologists to pore over thousands of films without knowing where the patient feels the pain. They are bound to make the occasional omission.

The care with which we answer patients' questions is also a useful exercise in CME and good practice management. I arrived in Australia as a dedicated explaining doctor when it appeared that nobody told anyone anything. Even the pill bottle was labelled 'the tablets' and the patients had no way of knowing whether they were taking my digoxin and that prescribed at the Royal Melbourne Hospital concurrently. Thank Goodness this has changed and patients are accustomed to questioning, even though sometimes they get too worried about the answers.

Printed resources

Our own libraries get too easily out of date, and the publishers say that GPs don't buy books. Perhaps they go to the medical library, and we are very lucky to have so many good free journals in Australia. The pharmaceutical industry deserves some credit, so long as we maintain a critical and watchful attitude to the material that is presented. Fortunately, the computer age is now bringing efficiency in educational resources to isolated doctors.

The honorary system

In the days before Medibank (Mark 1) everybody bulk-billed their pensioners for services limited to home visits or surgery consultations. There was no recourse for pensioners to special investigation except through the public hospital. For reasons of further education and to provide that service direct to my patients I joined medical outpatients at the Royal Melbourne Hospital. Teaching combined with patient investigation was advantageous to the patient, the hospital (for they got our services at no cost) and ourselves. It meant sacrifice of otherwise free time or of earning capacity. It also meant that together with the very long hours of practice work, effectively there was a 'widow' at home caring for your children. Ten or 11 pm, after the children are asleep, is too late to arrive home when this becomes a daily habit. Conscientious GPs of my earlier days made inadequate fathers.

It was also interesting to note that some patients preferred a continuing attendance at hospital outpatients where you were a specialist and wore a white coat, rather than seeing the ordinary 'run of the mill' GP that you were at the surgery!

In the late 60s Betty became ill and ultimately died from bronchogenic carcinoma. I left the Royal Melbourne Hospital to provide greater care for my boys, and until I met Iris I was miserable and lonely.

Iris and I found that we had exactly parallel histories. She had joined the Wrens soon after I joined the navy. She was married to a naval officer when I married a naval nurse. On postwar demobilisation both husbands had undertaken medical training in UK. Both families had migrated to Australia. She went to Perth, and both of us were left alone. It didn't take very long to marry her! But we were left with our conjoint left ventricles in Perth whilst physically residing and working in Melbourne.

It was amazing to hear of the change that my patients observed in me. I hadn't noticed any difference in my standard of care, but they had. 'How wonderful I looked', was the usual remark, and these comments demonstrated the importance of a happy and supportive home life to a doctor. We must study our family relationships, and ensure that there is a budget of time between work, academic activity and home. Thank goodness times have changed for to-day's young professionals. But then they have a different set of pressures and problems.

Lastly, the College

Two things happened to me on the same day early in 1972. Iris was involved with the organising committee for the Fifth World Conference (WONCA) in Melbourne, and she asked me to organise some private dinner parties. I did this, and I also wrote a report that delighted Monty. One thing led to another, and there seemed to be a hundred and one different things to organise, and then I found myself appointed as honorary secretary to the conference.

Like so many others in the faculty we worked our proverbial butts off for months because we couldn't afford to engage professional organisers. It was fun anyway. But every time I see Monty Kent Hughes' portrait staring directly at me in Trawalla I remember taking him home at 4.00 am because he was just too tired to drive, and then doubling back to snatch a couple of hours sleep before getting to the Masonic Centre to start things going at around 7.30 am. Thank Goodness our conjoint family was old enough to care for itself and that Iris and I could get on with the conference and all its overseas visitors.

The other thing that happened is that I answered a call for 'new blood' for the Victoria Faculty Practice Management Committee. I turned up to the building in Albert Street to find empty darkness, and I was just about to leave when Wes Fabb arrived having forgotten his keys. Together we burgled the place, and I found that the two of us constituted the meeting. A more satisfactory quorum exists today. I found too, that Wes was on his way to do other very important things, which have revolutionised the quality of training for general practice. So I found myself chairman of a one-man band in Victoria, but *ipso facto* membership of a group called the Practice Management Committee of Council of the College.

It is really amazing what happens in Australia when you get together for a weekend with like-minded people from every other state. The dynamic energy created by such a combination is difficult to believe. The worst thing that the College should do if it is short of funds is to restrict the meetings of its productive Committees of Council. Much may be done by efficient correspondence through an active chairperson. But as the Health Insurance Commission in its wisdom disallows benefits for any medical service which does not involve face to face contact between doctor and patient; the eyeball to eyeball meeting with one's trusted interstate colleagues is vital to the success of the College.

So from 1972, I have devoted a portion of my time to designing, writing, teaching, and creation – with my colleagues – of systems of care. In this privileged role I learn much, and it is a delight to puzzle out systems of practice management including preventive programs, flexible enough to be used in the vast majority of situations.

Dr Gawthorn with colleagues
Drs Frank Fry, Peter Joseph and Clive Auricht

The College is to be thanked for allowing me this privilege, and my partners deserve my gratitude for being available to try things at a draft stage. Particularly, I would like to mention Selwyn Carson of Christchurch, New Zealand for the years we have spent together with others in work on the *Manual for general practice*, which has now been copied and used throughout many parts of the world. We must also not forget the many other colleagues from overseas. The opportunity to share experiences at international conferences is an important component in CME, and we can always learn a better way to do things by visiting other practices. How often do we visit the people from across the road or invite them over for a cup of coffee?

Lastly, Iris is to be thanked for all her work for the College and for helping with all my work. She has been instrumental in starting much of it.

Edward C Gawthorn
Dr Gawthorn died in February 2010.