Healthcare in NHS hospitals

I have a good medical background. My grandfather was a colonial medical officer. My father was a consultant physician at two London teaching hospitals before and in the very early days of the NHS. My mother was an army nursing sister in the First World War. I qualified in 1945 and worked in teaching hospitals until 2000. I saw pre-NHS medicine, army medicine and US state hospital medicine in the course of my career. I believe this gives me a good background for judging what goes on in a hospital today through patient's eyes. We now have what I think might be called the 'right big toe doctor' as opposed to the 'left big toe doctor' profession. Unfortunately they do not always communicate.

I was admitted to hospital, after a 17-week wait, for what I reasonably considered a rather urgent requirement. I was told this would be a 24-hour procedure under local anaesthetic. On admission I was clerked by a very pleasant young senior house officer and told I would be operated on at 1.30 pm and should not eat or drink after 10 am. At midday I was told to put on a theatre gown and an antibiotic drip was set up. All unexceptional, but at 1.30 pm nothing happened. An hour later I was taken to the theatre but had not been given an explanation for the delay – it would have been courteous. In the theatre I saw a young doctor whom I had never seen before. He was very polite and called me 'Sir', the first and only time this happened. Having inserted the local anaesthetic he immediately made the first incision before it had had time to work. It was not too painful but left me wondering what might follow. I was told I could watch the procedure on a monitor if I wished. I would have liked to but, being unable to rotate my head through 160 degrees, I was unable to do. At two points in the procedure the anaesthetic was clearly inadequate. It could have been a very frightening experience for an apprehensive patient.

By the time I returned to the ward my bladder was full. Being at an age when it is impossible to urinate lying down I tried to stand but was told this was very dangerous and I must stay in bed for six hours. Acute retention is a very painful experience I would wish on no one. I was assured that I was dehydrated and all I had to do was to drink, and that I was a doctor and I ought to know better. I longed for a drink, my mouth was like sawdust, but I knew this would only aggravate my intense discomfort. When no one was looking I got up and tried again but it was too late, nothing would come. Some four or five hours later I was catheterised, with an audience. By that time I did not even feel embarrassed; it was just a great relief. But I should not have needed to suffer for this length of time. Next I was told that my restlessness had resulted in a large haematoma at the operation site and a sandbag was applied. It was too lumpy to work and kept on falling off despite my best efforts to keep it in place. Finally a senior nurse came and applied a pressure bandage, which although necessary added to my discomfort. By lights out I wanted to sponge my face and hands and have my sheet returned to some sort of order. It never happened. At about 6 pm I asked for pain killers. I was given two paracetamol tablets; it was about as useful as sacrificing a goat to Asclepius. A doctor would have to be found to prescribe something more. At 9 pm I was given cody-dramol and at last relief.

After a sleepless night I was offered some rubbery toast for breakfast. Although still dehydrated I was refused a second cup of tea. A third doctor looked at the wound and said that provided the post-operative X-ray was in order I could go home. That was it. I saw three different doctors, once each. I wonder if they ever communicated with each other. I never saw the consultant under whom I was allegedly admitted. Finally the lunch I was offered was scarcely worth eating and had little nutritional value as far as protein content was concerned. Any self-respecting chef would have shot himself for such an effort; I wondered if assisted suicide was permissible under the circumstances?

I do not wish to criticise individuals. All did their appointed jobs, as laid down by protocol, efficiently and with kindness. I was admitted for a single specific procedure and this was carried out and I left for home on time. But in my view the system failed. It felt like being on a production line. No thought was given to me as an individual with, possibly, related or other problems. What was missing was what Wordsworth called 'little unremembered acts of kindness and of love'. The experience was more traumatic than necessary and could have been improved at no additional cost. As I have already stated, it could be very frightening for an apprehensive patient or one without any understanding of hospital life. As a profession, doctors and nurses should aim for more compassionate standards. I was probably as guilty myself in the past of similar oversights and I most certainly apologise for these, *mea culpa*. I wish to cause none of my carers distress or seem ungrateful; I am indeed truly grateful for all they did for me, but I will sign myself

RETIRED PHYSICIAN

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Emerging concerns abour Iran's scientific and medical future

Habibi *et al* wrote eloquently about how the difficulties and setbacks that Iran has experienced in the past three decades have impacted on the growth of scientific knowledge in the country, and the effect that recent international isolation has had on promoting autonomy in scientific endeavour whilst retarding international scientific collaboration.[1] The British Council in Tehran has been developing international links and encouraging exchange programmes, and we were fortunate enough to be among 14 clinicians and other professionals to be invited to a recent Medical Collaboration Week run by the

Iranian-British Medical Communication Association, jointly hosted by Tehran University of Medical Sciences and the British Council. The conference was busy and interactive, and we were struck by the enthusiasm of the audience, and their desire to increase collaborative links between our two countries. The hospitality we received was extremely generous and indicative of their wish to overcome a sense of professional isolation. We would strongly encourage their efforts to transcend current political obstacles to improve professional links between our countries, and hope to find ways to increase collaborative research and exchanges.

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Reference

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Should our medical records be automatically centralised?

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Like many people I am uneasy about the explosion in the amount of information about us held by others. The proposed centralisation of medical records is yet anther example, so I raised it with Charles.

'Charles, I am very concerned about the proposal to centralise the electronic records of all patients and it sounds as though it may be made compulsory.'

He intervened asking, **'Why "electronic", Coe?'**

'Why do you ask?'

'Why not "paper" or for that matter any other type of record?'

I hesitated, so he continued.

'Do you think there is such fundamental difference between electronic methods and writing to justify different handling or indeed specific legislation for the former?'

I suggested, 'It is easier to distribute widely electronic information than written notes.'

'That is probably true,' *he replied, adding,* **'and when data protection was introduced it was partly in response to this well-conceived impression. However, I am sure that public misconception that electronic data are necessarily less secure than the written word weighed more heavily on the legislators when drafting the bill.'**

When I looked doubtful, he explained: **'As written records are as secure as the strength of the box in which they are kept, so electronic records only as secure as the password and the encryption.'**

'And wrong as it may be, just as screens are left on, so clinical notes are often left where anyone might see them.'

'And to labour the point, written notes do not have an automatic time-out!'

As usual he had focused the discussion on the real point at issue.

'So centralisation is the fundamental cause for concern.'

'Yes, Coe, and subsequent data protection legislation has recognised this. But to return to your specific point, would you object if downloading to the centre were voluntary?'

'No, provided the patient has an absolute say,' *I replied.*

'But that could never work well: there is plenty of universally accepted, albeit often unrecognised, precedent to the contrary.'

Seeing my astonishment, he asked, **'Do you ask permission before making written notes about a consultation which automatically becomes the physical property of the Trust or the Secretary of State?'**

'Never! If I did I couldn't do my job properly!' →