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Why I (still) enjoy doing outpatients

Good morning, everyone. My name is Kathy Webb-Peploe and to start with I'd like to introduce myself and talk about the context in which I practise.

I grew up in a family where there were many doctors. Although my mother isn't a doctor, her father was a gynaecologist and obstetrician in Lausanne where she grew up (hence my fluency in French) and her brother was a psychiatrist at Préfargier, a psychiatric hospital in Neuchâtel. My father was a cardiologist who worked at St Thomas' Hospital in London. His father had been a missionary doctor with Amy Carmichael in India and then a GP (family doctor) in Lymington on the south coast of England and he met my Dutch grandmother who was a nurse in India. I think I first came across the books of Paul Tournier when I was a teenager, but I don't really remember. What I do know, is that his approach to treating patients has hugely influenced the way in which I practise medicine, leading me to try and take into account more than just the physical symptoms and signs of the patient in front of me; their home circumstances including how much support they receive from family and friends, their fears about how the disease will affect their way of life, their beliefs about taking tablets, fears about the future, about death. And as a Christian who wants to do God's will for me and the people I come into contact with, I try to listen to what He is telling me to do in different situations. Most days, I find myself praying as I drive into work that I will make the right decisions for my patients and for the staff I work with, the junior doctors in particular.

At the moment, I have 21 patients under me on Eartham ward. The aim is to cohort all patients with heart failure or fluid overload on my ward, but in practice, we look after patients with a variety of other illnesses as well. I do a general cardiac clinic on Tuesday mornings which is a mixture of new and follow up patients and every other week I do a valve clinic on Wednesday morning, seeing patients who have had a valve replacement, or who have valvular heart disease and who I am following up to make sure they haven't reached the stage of needing intervention. When I became a consultant at Worthing in 2004, the senior cardiologist had a policy of seeing patients once, organizing appropriate tests and then writing to the GP with a plan and never seeing the patients again. If patients had to come back to clinic, they saw the registrar (doctor-in-training). Great pride was taken in having as high a 'new to follow-up ratio' as possible. Few of my colleagues would have said they enjoyed doing outpatients. In fact, my senior colleague used to joke that he'd rather do ABC (anything but clinic).

I started noticing how many patients came into hospital with end-stage aortic stenosis (severe narrowing of the aortic valve, the outlet valve of the heart) – a distressing condition to treat as the patients are breathless or very oedematous and the symptoms are difficult to treat without dropping the patient's blood pressure or inducing liver failure because of the low cardiac output. If you catch aortic stenosis early, you can replace the valve and give the patient many years of symptom free life. I decided to set up a valve clinic, so I could monitor patients with mild or moderate valve disease including aortic stenosis and send them for surgery to replace or repair the valve in good time even if they had minimal symptoms. I was able to help even more patients with aortic stenosis, however elderly and frail, when a new percutaneous way of replacing the aortic valve was introduced; TAVI or transcatheter aortic valve implantation. In time, minimally invasive ways of treating mitral valve disease have also become available. I also chose to follow up patients who had had valve repair or replacement (many of my colleagues would discharge them to the care of their GP). If it were a competition to get the highest new: follow-up ratio, I would easily lose, but over the years I have worked at Worthing Hospital, it is this clinic that has given me the greatest satisfaction and forged the strongest relationships with my patients. Seeing them no more than once a year is enough to build a picture of what their 'normal' is, what family stresses are going on in their lives, what has happened in their lives in the past which may well influence how they approach their illness, or whether or not they will agree to go for surgery. I can't put it better than Helen Salisbury who wrote in an article entitled 'The urgent and the important' last year : *'These visits* (in her case to housebound patients) *are my opportunity not only to check blood pressure and review medications – which arguably could be done by other team members – but to update my knowledge of my patients. How quickly do they move? How sharp or clouded is their vision, hearing, and intellect? I like to have a mental image of each of my elderly patients so that, when they do become unwell, I know what their normal is. This informs conversations and decisions made with their families and other health professionals.'* (BMJ 2023: 380: p209).

I will see a sick, distressed, breathless patient in a very different light if I have met them before in clinic and know that they are normally active, love working in their allotment and growing tomatoes and runner beans, are the main carer for their frail wife. It is too easy to look at a patient's date of birth and jump to conclusions about their usual quality of life. I have looked after a lot of patients on my ward in their 90's who were living well and independently until the illness that brought them into hospital and under my care. Having got to know a patient, knowing their background, what they have been through, what is going on in their lives, makes a big difference to how I assess them in their current illness, the decisions we make together about their future management. And that in turn gives me far more satisfaction than seeing a patient once and making life-changing recommendations about their future based on one 20-minute appointment. For some of the patients I see, there is no possible treatment. They are too frail, their cardiac anatomy is not suitable for intervention, they have dementia (which my colleagues doing TAVI now regard as an absolute contra-indication to intervention). Then, my only option is to accompany them in their illness and treat the symptoms as they appear. I have repeatedly seen in my practice the truth that 'for people living with persistent illness, empathetic listening, forming a connection between the patient and the healthcare professional, can be therapeutic' and not just in patients suffering from chronic pain as in the article I found this quote in. (Chronic pain: supported self-management. BMJ 2024: 384: e072362).

Chronic heart disease can be viewed as a journey with a beginning as we set off together, a middle where I might make various recommendations about drug therapy or referral for surgery and an end where the patient is no longer responding to treatment, or has become very frail, and my role is to accompany them towards death. Part of what I enjoy about clinic is that different patients that I see in a single clinic will be at different stages of our journey together. As I write this, just this last week, I had two patients come and see me who had a bicuspid aortic valve. This is where the aortic valve has two cusps rather than three and patients run into trouble with the valve narrowing or leaking, and they can also develop a dilated aorta which if not operated on might dissect or rupture when it reaches a certain size. They were both well and had had echoes (ultrasounds) of their heart in the past, but no-one had really explained the implications of their abnormal valve to them. One of the patients walked into my clinic room saying, ‘I don’t really know why I’m here.’ So, it was very satisfying to spend time explaining their condition, talking about what they might expect in the future, why I would want to see them once a year to monitor symptoms and to do an echo. For those patients it was the start of my journey with them. I have a number of patients I follow up both before they have their valve replaced and after their procedure. We get to know each other, and I learn to recognise when the patient in front of me is particularly anxious about what the future might hold. Because the computer system at my hospital does not ensure that the patient sees the same doctor each year, or even gets an appointment at all (we ‘lost’ a number of patients on the clinic waiting list when we changed computer systems just over a year ago), I started searching through our waiting lists and booking almost all my clinics myself to try and make sure I see the patients that need to be seen, and if possible, see the patients that I have seen previously. As Cathy Stannard and Colin Wilkinson wrote in their article in the BMJ on the treatment of chronic pain, *‘Compassionate and consistent relationships with clinicians remain the foundations of successful care. Research show that what people want most is a strong, empathic relationship with their care provider. They want time to discuss what matters to them and they want easy access to support. Shared decisions and personalised care are fundamental to the successful support of people in today’s healthcare landscape.’* (BMJ 2023; 380: p170) Practising medicine in that sort of fashion is so much more satisfying than seeing a patient once for 15 minutes and never seeing them again.

Although I may see patients with similar or identical conditions, one of the things that makes outpatients so interesting and enjoyable for me is that no two patients are the same. They pay me the honour of sharing their story with me and in return I do my best to listen to them, to accompany them, to hear what they are telling me. In his book ‘The meaning of gifts’, Paul Tournier writes : *‘… the true meaning of love is understanding the other, attempting to know him and to recognize him … as a person. That is to say, seeing him as a being distinct from all others.’* Although Tournier is writing this in the context of parents giving gifts to their children, it resonated with me as I started to think about what I might say in this talk. One patient I saw last week who has a dilated aorta and had been seeing one of my colleagues came into clinic and for several minutes spilt out her anxiety about the fact that it had taken longer than she expected for her to be seen again in clinic. She had been told she would be looked after and then had heard nothing. She was upset and worried about her condition. Once she had unloaded, we could talk about her recent tests, about what further tests I planned to do, how if she was worried, she had but to ring my secretary who would pass on any messages to me. Several times during the consultation (with a junior doctor also sitting in the room) she thanked me for allowing me to express her frustration and feelings in a way that she hadn’t felt able to do before. I didn’t ‘treat’ her, I didn’t alter her medication or recommend some big procedure (although I think she will need to have her aorta replaced quite soon which is a daunting thing to contemplate as a woman in your 40’s with 4 children) but she felt able to tell me how the wait to be seen had made her feel. Helen Salisbury writes about *'the particular joy in holding a personal list, where we add to our knowledge of patients incrementally, over many brief interactions. Each consultation builds on the last, and relationships that may have started out prickly often become comfortable as trust builds over time. It makes the job both manageable and satisfying. This is family medicine: we value building relationships and understanding the psychological and social context of our patient's symptoms alongside an accurate history, examination, and medical management. It's hard to do well in the space of a single appointment, but it's much easier with repeated consultations.'* Of course, when a patient expresses their appreciation to me, that is also part of why I enjoy doing outpatients. Allowing patients to talk is also why I often run 30-60 minutes late by the end of clinic. 25 minutes for a new patient and 20 minutes for a follow up is not nearly enough sometimes.

In an article written by Paul Tournier for 'LADAPT' (my copy of the article doesn't give the date it was published), he writes something that I think is so important as I keep seeing my patients in clinic : *'If our task is dual, it is that the patients' need is dual, the need of a scientific treatment which is as efficacious as possible, and the need to not be alone in the ordeal… Every illness and every infirmity brings with it a procession of renunciations, difficult to accept, many of which will be permanent, even after a clinical recovery. Every rebellion is an aggravating factor, every acceptance, a factor contributing to healing. But acceptance is hard. What can help? I think, above all, feeling oneself understood. One can accept everything when one is not alone. And it is always difficult for the well person to really understand the sick person, just as it is for the rich person to understand the poor person, the happy man to understand the one who is miserable. Sometimes a patient will tell me; "I have confidence in you, because you understand me." And they say this, before I have understood anything about their case. They mean by this that they feel understood as a person and not as a clinical case… I think that medicine of the person is that double attention to the clinical case and to the person. The task of the doctor is first to heal, but it is also to help people to grow, to face up to their problems, to thrive.'*

Paul Tournier emphasizes the importance of a reciprocal relationship between doctor and patient, a relationship between equals. He writes in the same article; 'The doctor is also a person, with their joys and their sorrows, their conflicts and their affections, their successes and their failures, their hopes and their disappointments, their rebellions and their impulsive actions. Also, with their regrets.' One of the things that I appreciate about following patients up over several years is the fact that they feel they can share things with me that perhaps they might not share with someone they were just meeting for the first time. I think of a lady who came to see me a few weeks ago. She was elderly, frail but with immaculately styled hair and clothes. Her two sons live a long way away. She has chronic valve disease which I can't fix as surgery would be too risky in someone as elderly and frail as her so all I can do in clinic is check her symptoms and adjust her drug therapy if appropriate. At the end of our consultation, she told me a little about why one of her sons had moved abroad. He had met his male partner here in the UK and she in the most understated way told me that 'in those days' it had not been easy for him. They had decided to move to his partner's home country where it was easier to be in a gay relationship at that time. She finished by saying she still writes a birthday card to her son-in-law every year and thanks him for the way he takes care of her son who is not in good health himself. For some reason, that conversation stuck with me – this dignified woman, coping on her own, talking about something which must have been very difficult for her. What is more personal than talking about the suffering or difficulties experienced by one of your children? And I was only her cardiologist, privileged to have her share her journey with me. David Loxtercamp, a family doctor in Maine, USA wrote back in 2015 in an article for the BMJ; 'Being understood and having your doctor (or any caring person) take an interest in you and in the most guarded, frightening, and intimate parts of your life is therapy itself.'

As I write this on Good Friday morning, preparing to travel to Cambridge to sing in King's College chapel which some of you will have had the chance to see during the tourism days, I am thinking back to yesterday afternoon's clinic. Perhaps because it was an extra clinic I had organized for urgent patients, it had a greater variety of patients than normal. My first few patients included two who had reached the stage where they needed intervention on their valve. I had seen them before and I had written to them about the latest findings on their echo, so our discussion about where they would like to go to have their procedure hadn't come as a complete surprise to them. Another lady had her valve repair at the end of last year and was frustrated at her slow progress. She had seen my registrar in January still breathless and exhausted and I had popped in to talk to her and examine her and we had organized an echo which showed that her valve repair had been successful, and her heart was pumping strongly. I spent a while answering her questions and encouraging her to keep going. She admitted that although she felt exhausted the day after a happy day with her group of single friends, her energy levels were gradually improving. Medically, there was nothing I could do to improve her symptoms, but once I had explained her echo findings, listened to and tried to answer all her questions, assured her that she no longer had 'heart failure', she left happier. I could not explain why it was taking so long for her to recover. All I could do was encourage her and listen to her. My penultimate patient was a lady who I had last seen several years ago with severe aortic stenosis. I had offered her a valve replacement. At the time, she felt well and in spite of my attempts at persuading her to have the valve replaced, she had declined. She reminded me that I had said that whether or not she had the procedure, I would continue to look after her. And now here she was in a wheelchair, severely short of breath even at rest in fast atrial fibrillation (an arrhythmia). I again talked about replacing the valve, but she didn't think she would survive it and again she refused. I talked about DNAR forms (she already had one and would not want to be resuscitated) and asked her to keep it readily to hand at home. I talked about asking her GP to do an advanced directive so that anyone called in to see her would know she did not want to come into hospital and about asking them for a referral to the hospice. Her daughter-in-law was visibly crying by the end of the consultation and asked me how long she had to live. I couldn't bring myself to tell the bald truth that I don't think she has long so I used a phrase beloved of GP's; 'I would be surprised if she is still alive at the end of the year.' I gave some tips for dealing with her breathlessness and prescribed a low dose of diuretic, increased her beta blocker to try and bring down her heart rate a bit and gave her codeine for the panic that accompanies her breathlessness sometimes. It felt like I was tinkering round the edges. What she had needed was a new aortic valve which she was still refusing (and to be honest, in her current state, I was not sure I would have managed to persuade my colleagues to do even a percutaneous valve replacement). At the end of the consultation, she grabbed my hand and thanked me. I was almost in tears myself. Her daughter-in-law then said that she wouldn't have left the house to come to clinic if she hadn't been seeing me. They had rung my secretary to check that it would be me she saw. Those many years of following her up as her valve narrowed and she felt well did mean something. It meant that when she felt desperately unwell, she knew me and made the huge effort to come and see me. Some years ago, much was made of an innovative way of following up patients with valve disease. A hospital in Kent set up a clinic run by cardiac physiologists (who also sometimes did the patient's echo). Anyone they thought needed medical attention could be passed on to the doctor. That is all very well, if you are trying to save doctors' time (and money) but the patients miss out on the opportunity to get to know and trust their doctor when they are well, so that when they develop symptoms, they will feel able to talk to their doctor, who they know, about it. It still surprises me how seeing a patient once a year can build relationship and shared memory and stories. The patients remember far better than I do. I have to rely on what I write in my letters to their GP to remind me and I try to include the personal as well as the medical to remind me to ask about their tomatoes, their children in Australia, their sick husband or their grandchild studying medicine.

And then in complete contrast my last patient of the afternoon was a young girl in her twenties who I had met in the echo department where I had been called to see her because she had a severely leaking aortic valve. She had a history of mental illness and of being a bit unreliable with keeping appointments. I referred her to my female surgical colleague in London who, after discussing the different valve options decided to do a minimally invasive tissue valve replacement. She walked in smiling broadly, looking radiantly well. She is much happier in her new job than when she was working at a supermarket, she and her partner are thinking about starting a family and I was struck by how different she appeared to when I first met her. Because she has a tissue valve and is not on warfarin, she should be able to have a normal pregnancy and delivery and she has been told her valve should last her 30 years (the old tissue valves used to last 10-15 years). It was a striking contrast to my previous patient but with both, these were people that had seen me before, knew me and, I hope, trusted that I would look after them. I came home yesterday evening drained, but deeply content that it had been a clinic worth doing. I am absolutely convinced that continuity of care matters greatly, not just to the patients but also to me, the doctor, seeing them. Relationship is an important part of the therapeutic process. It matters to patients and to their relatives and it matters to me the cardiologist seeing them. David Loxtercamp writes in the preface to his book 'What matters in medicine'; 'Living in one, small, remote community has brought my colleagues and me to the center of community life. We are building a practice in the image of what our patients tell us they need. They need a family doctor who knows and cares for them. They need a family practice that is community-oriented, generalist-minded, and relationship-centered. They, like their doctors, know that the pursuit of health begins with a close, committed regard for the basic human need for conversation, friendship, and hope.' My patients also need a cardiologist who knows and cares for them, is generalist-minded and relationship-centred, who can give them conversation, friendship and hope.

One of the other reasons I enjoy outpatients has to do with the satisfaction of solving the puzzle of diagnosing what is causing my patient's problem. Because I specialise in heart failure and valve disease many of the patients that come to me are breathless or have swollen ankles. Sometimes the answer is immediately apparent once they have had their echo (ultrasound of the heart). They may have a heart that is not pumping properly or a tightly narrowed valve or a valve that is leaking. For those patients I can give them a reason for their symptoms along with advice and treatment. Sometimes it isn't immediately obvious why their heart is not beating as strongly as it should. Was it a virus? Do they have silent coronary disease (in other words have they had a heart attack in the past without realising it, or do they have narrowed coronary arteries)? The challenge is then to do the appropriate tests to work out why their heart is not working as it should. But some patients have a normal echo, normal lung function, no evidence of coronary disease on CT scan. Why are they breathless? Sometimes, their expectations of what they feel they should still be able to do are too high. I think of an energetic older lady I saw recently who walked briskly with me into my consulting room (I almost always go to the waiting room to collect my patients). She had gone to her doctor saying she was more breathless. All her tests had been normal, and I ended up having to gently tell her that perhaps she might have to accept that she couldn't walk as fast as she was used to doing any more. Helen Salisbury wrote about this in the BMJ in an article entitled 'Is it just my age, doctor?' 'We slow down as we age. Most of us become less fit and less flexible. Eventually, our memory fades along with our sight and hearing, until we reach the last of Shakespeare's seven ages – a "second childishness and mere oblivion, sans teeth, sans eyes, sans taste, sans everything." Long before this final stage, however, it's common for people to visit their doctor and ask. "Is there something wrong or am I just getting old?". Their worries may be about loss of stamina, increased breathlessness, or problems with continence or sexual function. Whether they seek advice at all will depend on their expectations, driven by the experiences of their family and the people around them… When they do ask that question about age, it's my job to take a careful history and look for treatable causes. Has there been a recent change? What can they no longer do that they once could? Only when I've satisfied myself and the patient that there's nothing my medicine can fix can we attribute the decline to age. … My job is to help my patients to age well and to notice any sudden and unexpected downturn. As ever, **continuity of care is the magic ingredient of general practice** that enables us to work out when investigations and referrals are likely to be helpful – and when they're not' (my emphasis). I would argue that continuity of care is equally important when patients have been referred to me, the hospital specialist. If I do decide to do further investigations and they come back normal, looking my patient in the eye and reassuring them that I have found nothing wrong is, I think, an important part of what I do.

In conclusion, I suppose the reason I still enjoy clinic comes down to the fact that I enjoy hearing my patients' stories, working out why they have their symptoms, sometimes being able to do something to cure or alleviate their condition, but more than anything, I enjoy the privilege of accompanying my patients and being given a small window into their lives. Continuity of care, seeing my patients over many years, building a relationship of trust and confidence and hearing them say as they walk into my clinic room how pleased they are to be seeing me again – continues to give me great satisfaction. It is one of the main reasons I still enjoy going to work and I realise on a daily basis how fortunate I am.

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