A really bad locum

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Experience

Expérience

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For reasons of confidentiality some of the details in this article have been altered.

Dr. Smith is getting close to retirement. I can tell this without ever having met him. I don't remember seeing him when I worked in this clinic before; maybe he was away then, too, and had some other locum filling in. One of the patients mentions that Dr. Smith will be retiring soon, but I would have guessed it from the fact that so many of his patients are old. All of those in hospital are over 70, and one is over 80. They've probably been coming to him for 30 years. People that age seldom change doctors.

The other clue is the office. It's a mess. The drawers are jammed full of papers, most of them years old. There are no new books on the shelves, no colour atlases of dermatology, no zippy paperbacks on geriatric assessment or family counselling or new management strategies for high cholesterol. In short, there is none of the sort of thing you find in the offices of youngish doctors who still want to learn. There's an obstetrics text, but it's 20 years old. The only other book about having babies is the 1944 edition of *Childbirth Without Fear*. There's nothing on pediatrics. But there are a lot of drug-company throwaways.

I stare glumly at the shelves. Perhaps it's all a sign of an incredibly experienced, talented doctor who committed everything to memory years ago. He must be caring for his patients so much better than I could, judging from the way I always have to go and look things up. Yet somehow I don't think so. It bothers me that he doesn't have any framed diplomas on his wall. He doesn't have *anything* on the walls, other than faded posters here and there. The big fat binder mailed out 2 years ago from the Cancer Control Agency is still in its plastic wrapper along with the treatment manual.

Then there's the tell-tale sign of the doctor who has given up: lots of drug addicts. His notes are very poor, but there are occasional pitiful comments about how the patient is "trying to cut down her use" of acetaminophen and codeine and how they "will see about reducing these drugs." There is no evidence on the charts that any patient has actually cut down on codeine or any other addictive drug. There's certainly no evidence from the patients themselves. On the very first morning I find myself prescribing over 450 tablets to the various addicts who want refills for a month, or 2, or 3. Some tell the usual lies about pills being stolen or lost. One claims his girlfriend has set fire to their apartment and burned up his pills. He is leaving that day for the detox centre and wants enough to last 2 months. He comes back 3 days later, not having left for detox, and with another story.

All of these patients have been taking 20 or 30 or 50 tablets containing 30 mg of codeine every week for months or years — usually as far as the charts go back. The young ones are obviously passing this doctor's name around and are probably selling their pills to the more pathetic patients, who are still on 15 tablets a day. Dr. Smith has made a brave note in one chart to the effect that the patient has agreed to cut down by 3 pills every 2 days. This patient tells me she feels bad. I explain that she is experiencing withdrawal symptoms and give her enough pills for the weekend.

Most of them claim to be having migraines. I make a stab at describing the difference between migraines, chronic daily headache and analgesia-induced headache. They switch to describing chronic back pain.

After a week of this I simply record the facts: "Patient is addicted to codeine and lorazepam." Then I write down the number of pills I've prescribed. A locum can't set about detoxifying people with addictions in the 10 minutes allowed for each visit, and I certainly wouldn't get any points for throwing them out of the of-

fice. I haven't been hired to destroy Dr. Smith's practice, although if you ask me this is the sort of practice that ought to be destroyed. Years ago I found myself working for a pill doctor who gave out tons of pentazocine and methylphenidate. I would have reported him to the college, but pretty soon he was struck off for selling prescriptions. So that was that.

The trouble is, of course, that these patients might not all be junkies. Maybe some of them *do* have chronic pain that has failed to respond to other measures. One, for example, is a middle-aged man who hurt his back on the job a few years ago and has been sucking up codeine ever since. Another is alcoholic and a former heroin user with "arthritis" and "fibromyalgia" and a frightening intake of acetaminophen with codeine. His liver is clearly packing up. After asking permission to speak freely in front of the neighbour who brought him in, I explain that the 2 kinds of chronic hepatitis that he got from dirty needles, his known cirrhosis and his alcohol abuse are putting him at serious risk of liver failure. Acetaminophen at these doses is poisonous to the liver, I explain. "You haven't got many liver cells left. If you keep drinking and taking pills you'll go into liver failure and then you'll die."

"I know," he says.

This is the response of quite a few alcoholics who are hanging on by one hepatocyte. They don't want to be healthy. What they want is to be dead.

Those who are not junkies often require other prescription refills. It seems that the old folks with bad hearts and diabetes are being looked after quite well, but it's hard to be sure because the charts don't have any problem lists or drug lists (unless they've been entered by other doctors) and they seldom have any record of a complete physical exam. Long ago I learned that the best way to find out about a patient is to look for a letter from a consultant, preferably an internist. They always take a proper personal, family and social history, do a complete physical exam, and give a summary of the patient's medical problems and medications. The very best GPs and FPs do this too, but such doctors are thin on the ground.

Few of the old people know what drugs they are on. Maddeningly, they describe the colour of the tablets, expecting me to know what they are. Sometimes I show them the colour pages in the drug book. There are *pages* of little white pills. One patient in 10 brings in the bottles; the rest say, "It should all be on the chart." I sigh and start flipping pages. What is legible is generally out of date.

None of this is terribly uncommon, and the old folks had no way of knowing they'd be seeing a new doctor this week, and probably Dr. Smith really does have their stories all catalogued in his memory for immediate access. Still, the old ladies don't seem to be getting breast exams or Pap smears or the other stuff we're supposed to be doing. I know male doctors have a harder time getting elderly women to accept preventive care, but still. . .

One of my teachers once said, "You can learn a good deal from the careful study of a single case." I've learned something from each of the doctors I've done locum work for. Quite a few are very proficient in one area or another — sports medicine, for example, or office surgery. Quite a few others impress you with their careful attention to *everything*. They've got shelves of patient information booklets and videos, new textbooks, nothing obsolete. When you talk to them you discover they've been keeping up with 20 different fields. Then there are the Dr. Smiths. What I've learned from them is the kind of doctor I don't want to be. ?