Transcription of Radio Ombudsman #16: Dr Tony Dysart on working as a GP during the coronavirus pandemic

Dr Tony Dysart talks to Rob Behrens about his journey from nursing to general practice, the challenges of being a GP during the coronavirus pandemic and how his lifelong values inspire him in his role as a clinical adviser at PHSO.

Rob Behrens: Hello, everyone, and welcome to Radio Ombudsman.

Welcome to our guest today, Dr Tony Dysart, who is a well-known colleague at PHSO. He's been with us since 2014 as a clinician and lead clinician. Tony, you're very welcome. Thank you for joining the show.

Tony Dysart: Thank you.

Rob Behrens: It's a tradition on this show to begin by asking people about their early life, where they grew up and what they remember about the values that were instilled in them. Could you tell us a bit about that?

Tony Dysart: Yes, of course. I grew up in Blackburn. I grew up on a council estate in Blackburn, living with my mum and two younger sisters. My mum and one of my sisters still lives there in the same house. I'm the eldest of three children, so a sister who's five years younger than I am, and one who's about eighteen years younger than I am.

My mum was a single parent. Throughout my childhood, really what I remember is of her working, doing various jobs, working in factories, working as a cleaner. That's one of the main memories, really, of my childhood: that she was always

out at work. She was a very hard worker. I spent a lot of time with my grandmother, my nan, who would look after me before school and after school whilst my mum was at work.

I had a reasonably happy childhood, I guess. It was an interesting time. I was probably the only mixed-race child, or only mixed-race children, on a very white, working-class council estate in the middle of Blackburn, in the middle of the ‘70s.

I think a lot of the issues around that time really seemed to pass me by. I wasn’t overly aware of any problems, growing up. I had a relatively happy childhood. I think that, like many people who were children around the ‘70s, I remember long summers, playing out for long hours, from 9:00 until 5:00, not really having a care, really.

I know that my mum wouldn’t necessary be that worried where I was, because I’d be playing out. There were no concerns, which is a big contrast to how things are these days, but, like I say, Blackburn in the ‘70s was rife with lots of racial tensions. I think that really passed me by. I think the reason for that is probably the kind of environment that I grew up in, with the care and protection, I guess, of my nan.

She’s been very influential in my life, throughout the whole of my life, really. She died when I was 15. I know that’s obviously a long time ago, but still I think the values that I got from her in my adolescence have remained with me for my whole life. She was very hard-working. She had eight children, a strong Catholic family, and had worked very hard through all of her life. She instilled into me that work ethic which I saw in my mother and which I’ve still got in me today, really.

Yes, so those are the, I guess, key things that I remember from being a child. I think the values that have lived with me today from that time are of how important it is to work hard. I think I always have worked hard, in whatever role I've undertaken. I think that comes from my childhood in Blackburn.

Rob Behrens: Thank you. Do you still have any religious beliefs?

Tony Dysart: I don't. I was christened Catholic, but I don't really follow any particular religious belief. My father is – was – Pakistani, and my mum's English, but, like I say, Mum was a single parent, so I never really followed my father's religion and really never chose to follow my mother's religion either. So, I'm fairly middle-of-the-road, really, and not particularly got any leanings to any particular religion.

Rob Behrens: Did you have a strong feeling of what you wanted to do when you were growing up, or did that come later?

Tony Dysart: That definitely came later for me, and later – a lot later, I think – than traditionally you would expect. I never really knew what I wanted to do. When I finished school, I left school with five O-Levels, not really sure what I was going to do or where I was heading in life.

Like I say, my family were all hard workers who worked in textile mills. I did originally, initially, got a job in a textile factory, working as a roller fitter, thanks to my uncles. It wasn't a nice job. It was a very lowly paid, very filthy job,

but it was my first experience of working. I knew then that that's not what I was going to do for the rest of my life, but again I didn't really know what I wanted to do. No-one in my family had been to university. No-one was from a medical background.

By chance, a friend of mine was a nurse and suggested to me that I should consider going into nursing, so that's what I did. I applied to go into nurse training in Blackburn and got a place in Blackburn School of Nursing, which at that point in time it was a traditional course. It wasn't a degree course, so my five O-Levels secured me a place on the course in Blackburn, which is exactly this month 32 years ago. I started working in the NHS thirty-two years ago. I trained as a nurse, and that was a three-year course.

I was never going to be a doctor from being a child. I never knew what I was going to be. There was never any pressure or any kind of feelings for me to go to university or anything like that, but I just think, again back to those values of working hard and striving hard, I always knew that I was going to do something different than the rest of my family.

I was relatively bright at school. Not a massively high achiever, but fairly bright and so that was encouraged. So, I knew I was going to do something different. If I worked hard and got a decent education or a qualification, I knew that would give me a better quality of life, I guess.

Rob Behrens: When you decided to go into nursing, was it unusual for men to go into nursing?

Tony Dysart: At that time, yes, it was. In my group of 30 nursing students, there were two men, so it was unusual. You were a bit of a novelty. Certainly within the group I trained with and on the wards, you were seen as a bit of a novelty, but it was fine. I think we just got on with that.

I don't think you were necessarily treated any differently. You still had to do the work, and you worked as hard as the other nurses, but certainly you were a novelty. That's changed massively now. I'm not saying… I wouldn't say that it's equal proportions, but certainly there are more male nurses now working in healthcare than there used to be.

Rob Behrens: I don't want to labour the point, but what you're saying is that in terms of ethnicity and gender you didn't experience any exceptional treatment.

Tony Dysart: Certainly I think about this quite a lot now. I think as you get older you reflect on life, and I think that, looking back when I was a child, I think there is no doubt that there were some times when I did experience racial abuse, or whatever you want to call it, in terms of name-calling and bullying. But I think, weirdly – and I don't know whether this is naivety or this is just purely being very innocent – I seemed to let that pass me by, really. It didn't seem to register with me as something that was very bad or something that was really horrible. It was just part and parcel of my life.

Again, I think part of that was, I guess, just being very innocent, but also I think having that protective family network that supported me as a child through that. I remember being taught rhymes about, "Sticks and stones may

break my bones," and those sorts of things. I couldn't remember what prompted those kinds of conversations, but, looking back, I guess it was because I was having names thrown at me and being bullied. So, we did have those conversations, but at the time it didn't seem like anything that was too harsh.

Certainly from a gender point of view, I think, if I'm honest with you, being a male nurse, probably you got treated slightly different by the other female nurses on the ward. I wouldn't say you got preferential treatment, but you certainly got treated differently, but at the end of the day you still had to do the same job and pass the same exams as the female nurses.

Rob Behrens: How long did you practise as a nurse for?

Tony Dysart: I qualified as a nurse in '91, went to medical school in 1997, so I worked as a nurse for about seven – six or seven – years as a general nurse, and then later as an intensive care nurse. Throughout that time I, again, striving to do something different, striving to better myself, I did a nursing degree at Manchester University. I did that part-time.

That's really what enabled me to go to medical school. I don't have any A-Levels, I don't have any science background, but, when I applied to go to medical school, I applied to do the pre-medical year first of all and then do the six-year course – do the five-year course. It was six years in total. The nursing degree was my entry into medicine.

Rob Behrens: But again I doubt that many nurses go on to become doctors. I think I'm right in that sense.

Tony Dysart: Yes.

Rob Behrens: So, it's quite remarkable what you've done.

Tony Dysart: Yes, you are. Again, in a year of about 300, I think there was another nurse. Yes, it's very unusual at that point for nurses to be going into medicine, and not really that encouraged. Like I say, I did a six-year degree compared to my 18-year-old contemporaries who all had science A-Levels.

That was because I didn't have that background in science or that level of academic qualification, but I still did have 7 or 8 years' experience as a nurse. Yet that didn't count, so I did an extra year, which was fine. I didn't mind doing that, but it did feel a little bit galling to have to do that extra year, given my experience.

I think the situation is probably very different now. I think they are recruiting more nurses to shorter courses to do medicine, but times have changed. I guess the need for doctors is very different now than it was all those years ago.

Rob Behrens: One of the things that I've noticed about you is that throughout your career you've chosen to do very difficult things. You chose to work in intensive care, you chose to work in palliative care, and you've worked in end-of-life care. These are not easy options.

Tony Dysart: No. I think they're challenging, definitely, and I think, again I enjoy a challenge and so I think I've always gone to jobs or to careers that have made me want to do better, made me want to do something different, and never been put off by the fact that they are difficult career choices. You might find yourself in difficult situations, particularly around the end-of-life work, but they're very fulfilling areas to work in.

My time in ICU was very challenging. You're dealing at that time with the most sick patients in the hospital, usually, and yet it's a very supportive environment to work in. You've got very good colleagues who are always looking out for each other. You've got immediate access to the medical staff, who can always help you, so it's a very supportive environment.

My work in end-of-life care was, I think, probably one of the highlights of my career in terms of working in at a commissioning level, so working at a level away from clinical care but actually at that level being able to direct where we were going in terms of managing end-of-life care in Heywood, Middleton and Rochdale. That was really interesting, really challenging, but really fulfilling in terms of the work that we did. The design of services that we were involved in, and the changes in the services that we were involved in, was pretty amazing.

That stemmed from my interest in end-of-life care, and the patients I'd cared for at end of life, and the services that I'd seen them receive, and sometimes not as good as I thought they deserved. So, going into a commissioning role to look at how we change that was really helpful for me in terms of, one, I could use my experience of working with patients at

end of life, but two, I could also drive through the changes that I thought would be beneficial to those patients.

Rob Behrens: Yes. Then you went on to become a general practitioner. Why? Why did you choose to become a general practitioner?

Tony Dysart: I was 27 when I went to medical school, so six years, 33 when I qualified. Throughout that time, I toyed with various options from a career point of view in terms of working in the hospital, but then very quickly I became a bit put off by the fact that you might have to do long weekends and you might have to do lots of night shifts, being on call. I felt that general practice might be more amenable to a better quality of life. I was going to be a bit older, so I was ready to not have to do weekends and nights.

Also, being a GP was very much suited to my personality, I think. I'm quite an inquisitive person. I like to know about people. I like to meet people. In general practice, you do all of that and plus some. Yes, so that was what guided me to that choice. I'm not sure whether it has turned out to be the quieter option of all the jobs that there are in medicine. It probably hasn't, but that's just the way it is. It's still very enjoyable and it's suited me. I think it's the right choice to have made.

Rob Behrens: You now work with the Bolton Community Practice. Which is a social enterprise. Could you explain to people what that means?

Tony Dysart: Yes. I've worked at Bolton Community Practice for about six years, similar to the time I've spent at the Ombudsman. The thing that attracted me to that practice was that it's set up as a social enterprise.

When I qualified as a GP, I joined a partnership, a GP partnership, which is the traditional model of how a general practice works, so you've got… We had five doctors, all of whom were partners in the practice so were, kind of, shareholders, I guess, in the business. They managed the business, they managed the staff; they decided what things were done in the practice, what services we provided. That's, kind of, the partnership model, which over time didn't really suit me and so I left that after about seven years.

Then I worked in Didsbury for a short period of time but then found Bolton Community Practice. As you say, it's a social enterprise, so that is very different from that partnership model. We still provide the same services as a GP practice, and we provide more unique services from Bolton Community Practice, but what the difference is mainly is that it's every member of staff is a shareholder, has a share in the business of the practice. We all are involved in making decisions about the direction the practice is going in, and major changes that might be being proposed. We're all involved in that decision-making.

We are very actively involving patients in that, as well, so we have a board. We have a medical director, who's a clinical person on the board, and then we have management, and non-executive members of the board, and patients. It's very democratic in many ways, compared to a GP partnership, which doesn't involve the whole range of staff. It can be

quite difficult to be part of if your values aren't linked to the values of the other partners.

Rob Behrens: Yes, okay, that's interesting. I think recently you've taken a group from our office to have a look at the practice in Bolton. How did that go?

Tony Dysart: Yes, so I was approached by the learning and development part of the organisation to ask whether I would be willing to host a visit. Of course, that was definitely no question about whether we should do that. It was a brilliant idea to take a group of caseworkers and managers to the practice to just show them, really, how general practice works behind the scenes.

Lots of our complaints to the Ombudsman are about administrative stuff, about people being removed from lists, about how cancer referrals are processed, about how correspondence is received from the hospital to the practice. It was an opportunity, really, to show staff and the Ombudsman just how a practice functions behind the scenes.

I think we had about 10 people visit with us, which was a really nice mix of caseworkers and ops managers, and we had the liaison team come with us as well. Yes, we just had a few demonstrations of how we work, how we process correspondence from the hospital, like I say. We had our secretaries talking about how cancer referrals are reported. We had our Medical Director talk about the general aspects of Bolton Community Practice being a social enterprise, the different services that we provide that might be slightly unique to other practices.

Then we thought it would be good for us to, as the PHSO staff, to give something back to the practice. So, the liaison team gave a presentation about what we do at PHSO and how we investigate complaints, the sorts of things that we see in relation to general practice at the PHSO, and how we manage complaints and how we're trying to support practices in dealing with complaints through the Complaints Standard Framework.

It was a really successful visit, I think. We, at the practice, really enjoyed it, really enjoyed having people come in to see us and see what we do. It's always nice to talk about what you do, and nice to have people interested in what you do. I think the feedback from the colleagues at the Ombudsman was very positive, too.

Rob Behrens: Okay, so I now get to the crunch question, which is I can see from our conversation that you're attracted to doing very difficult things, and then you decide that you want to join PHSO in 2014.

Tony Dysart: Yes.

Rob Behrens: What made you do that? (Laughter)

Tony Dysart: Yes. I think it fits in quite nicely with everything that I've done, really. I think all the time throughout my career I've been very interested in quality, I guess, and to make sure that what we do is of a high standard, whether that's nursing, whether that's medicine.

I've always wanted to strive to do things better, to do things differently; if things aren't right, to try and change things. If someone reports a problem with something, if it can be changed, if it needs to be changed, then we should change that. That's my kind of… How I fundamentally work, I think, in that I'm very keen on focusing on quality.

Then the opportunity came to work at the Ombudsman, and it seemed like that was just an ideal next step, really, in terms of trying to put into place the things that I'd done on a more local level in my own practice, or in my practice as a GP, but actually transfer that to a wider level. Not just focusing on what we do locally, but actually looking at whether that can be something that can affect and impact on services at a national level.

I think, when I first started at the Ombudsman, I didn't have such high sights. I didn't think that we would really be having that impact nationally. I think, when I started at the Ombudsman, I wasn't that aware of what we did, and still now our profile could do with being raised even further. I think we're doing that through the liaison team, but over the time that I've been at the Ombudsman it's become very clear the positive impact that we can have, and I think mainly through our thematic reports, our sepsis report, our end-of-life care report.

One of the things that really brought this home to me fairly recently, I was at a conference and got chatting to a psychiatrist. When they found out that I worked for the Ombudsman, the first thing they wanted to talk about was the Hart case and the eating disorders report, and it was just… That just brought home to me how… What effect that we do actually have – not just to the GPs in question when we're handling a GP complaint, but how the work that we do

can actually impact on things more nationally and really do have a positive change in the care that patients receive.

Yes, I guess it's a challenging job. Of course it is. We come across lots of very upsetting complaints, but I think fundamentally what we do is we change things, and, hopefully, we change things for the better. That's, for me, a natural progression in my career.

Rob Behrens: The time that you've been with PHSO, there have been a lot of changes.

Tony Dysart: Yes.

Rob Behrens: It's been a fairly bumpy ride between 2014 and 2020.

Tony Dysart: Yes.

Rob Behrens: The sepsis report that you referred to, the need to rewrite the 'Ombudsman Standard', the 'Donaldson Review of Clinical Advice'. How would you say it's changed in the time that you've been with us?

Tony Dysart: So, significant changes over that time and then undoubtedly impacting on how the clinical advice functions within the office. I think the review has come along at a good time. The results of the review are, hopefully, going to come to fruition over the next few months, I guess – or even longer, maybe,

with the whole thing relating to coronavirus – but I think over this last six years, yes, there have been lots of changes in senior management.

There's obviously been a change in the Ombudsman and the senior management team. I think that's been a very positive move for the organisation. I feel much more engaged with the organisation than I ever did, and much more able to – work at that level within the organisation than I ever did. You feel that your voice is being heard a bit more than it ever was, so I think that's all good.

I think that the role of clinical advice is changing within the organisation. That's probably a result of the review, and also, I guess, clinicians and lead clinicians in the clinical advice function trying to champion us a bit more at senior level. I think that's changing how we fit within the organisation, which I think is positive as well.

I think over time it's been sometimes some necessary changes, some much-needed changes, but I think that changes have, on the whole, been for the better. I think, when we come out of the review, hopefully we'll be in… Clinical advice will be in a different place than it was before, and we'll be much more engaged with caseworkers. We'll be working much more collaboratively, which is only going to be of benefit for caseworkers and clinicians, but also for our complainants, so I think significant changes but really positive changes.

Rob Behrens: Okay. I want to ask about your experience of working in the crisis that we're going through now, but just before we do that, I have colleagues in Canada and in Ireland who have responsibility for health, but they don't have jurisdiction over

clinical advice. They can receive health complaints, but they can't look at issues of clinical judgement in the health service. They're constrained only to look at service issues. They don't think that's necessarily a problem. What is your view about that generally?

Tony Dysart: I think… I'm not sure that that's the way I would see how we should work. I think that there are two different things on that. We're not a regulator, so we're not looking at a doctor's fitness to practise or a clinician's fitness to practise, but what we are looking at is an episode of care that might have not gone right, that might be separate from a fitness to practise issue but absolutely involves the care and the actions of a clinician.

I think that it must be difficult to separate the two, really, to look at service issues without looking at the people who are involved in providing that service, so I'm not sure how… I'm sure they do do it, but I think it would be very difficult to reach a judgement without looking at the clinical issues around how that service failed that individual.

Rob Behrens: Okay. Now tell me about working on the front line during the current crisis. What's that been like?

Tony Dysart: I think undoubtedly, obviously, it's challenging. We all see the news and see stories on the news about how the health service has had to adapt to deal with the COVID-19 situation. We changed how we practised, quite quickly once lockdown was announced. We have four branches over Bolton. We closed two of those branches in an effort to just consolidate

our staff to two sites to reduce the flow of patients, reduce movement, and, therefore, try and reduce the spread of the virus.

We then got staff working from home. I'm currently working from home as a GP, and we did that because, again, to try and safeguard ourselves for future developments. So, if staff who are working within the practice became unwell, the staff who were at home could then be shipped into practice to take their place. Fortunately, that's not been necessary. We've had one doctor who has been sick with COVID-19. He's better now, but that's the only one.

The big change is how we consult. Most of the consultations – 80% – are done over the telephone or via video link, so we get very, very few patients coming into the practice. The ones that have to, we've designated a hot and a cold site. We've got a hot site, which is where you would see the patients with potential COVID symptoms, and we've got the cold site, which would be everybody else, I guess, really.

What we do is we triage patients on the telephone and then direct them to the surgery should that be necessary, so we've not had to… We've been dealing with patients in a different way. We get a large volume of calls every day, so probably about 50 calls for each GP, which can be quite simple concerns, or they can be quite lengthy phone calls.

We had to buy our own protective equipment, which we did very early on again, before the stores started to run out. I think if we'd have waited, we probably would have had to wait quite some time and we would have exposed the staff to unnecessary dangers. We did that very early on, so we've never had to have a problem of staff not having PPE – protective equipment.

The biggest issue, I think, is dealing with patients over the telephone, and particularly dealing with patients with mental health issues over the telephone. I think that's going to be our big problem following the… When things start to improve, I guess, is that we're still going to have a big problem with dealing with people's mental health issues – not just people who had pre-existing mental health issues, but the whole trauma of going through this crisis is going to leave people very traumatically distressed afterwards. I think it's something that we're going to have to try to work out how we deal with, going forward.

We get complaints. Everyone is anxious at the moment. I think it's natural that we're all anxious about what's happening, about being unable to leave our houses. I think if you already have an underlying mental health problem, those anxieties have been amplified massively.

Trying to deal with that over the telephone is very difficult; trying to signpost patients to support, which is variable still in various parts, although there is now commitment to provide that support. You've got to try and get people to use that, and that's very difficult, and it's very difficult over the telephone.

We are consulting in a way that we never were trained to. I think on the whole, inherently, most GPs are quite empathic and we like to see patients. We like to hold someone's hand when they're distressed. We like to hug somebody if it's appropriate, because we know families and we know patients, and have done for many, many years. We can't do any of that. If you do see someone, it's with gloves, masks, and gowns on, so it's a completely different way of working. That's very stressful and very distressing.

Another issue, I guess – and that comes back to my end-of-life care work – is dealing with that aspect of the COVID-19 situation and having to talk to patients, to relatives, I guess, whose loved one has died in hospital and they've not been able to be there. Actually, the comfort that I can give them is on the end of the telephone, so it's just very, very sad.

Some of the stories that we're hearing are incredibly sad, about people being unable to go into care homes, unable to go into hospital to see their dying relatives. They're incredibly tragic stories. We're hearing more and more of them, and I think we will continue to do so until the numbers of people dying starts to fall.

Rob Behrens: Thank you for that. How are you managing under lockdown? What's it been like for you?

Tony Dysart: It's definitely a challenge, as it is for everybody, of course, but I'm working from home full-time. I live with my partner, John, who is also working from home full-time. Being together 24 hours a day, 7 days a week, is not something that we've ever had to do before, and I don't think ever thought we would have to do. That in itself is a challenge and we're coping reasonably well with it.

We're very lucky: we live just on the foot of Rivington Pike on the North of Bolton, so just outside Bolton. So, it's very easy for us to get out and go for walks. We also have a nice, relatively big garden, which again is very easy for us to just step out the front door, and sit out, and have a coffee and get some fresh air. So, we're very, very fortunate in terms of

what we can do what we can't do with the lockdown situation. I don't underestimate how lucky we are.

I think, again back to the people I talk to in my GP work who are living in apartments, who can't get out the house, who don't see anybody for a week on end, the situation some people are finding themselves in is very, very tragic. Luckily, we're not in that situation. Yes, I consider myself very fortunate, really.

The fact that we can't do things that we normally would do, that's just a small price to pay for, I think, the overall benefits that the country will gain from us just being in lockdown for this last five or six weeks and for however long it has to be. But I think at some point we will, hopefully, get back to doing the things that we like to do – going to the theatre, going to restaurants, going out for a drink to see friends – but that's some way off. I think it's a small price to pay to not do that, for the benefits that we're going to gain for not doing that.

Rob Behrens: Thank you for that, Tony. I want to end by asking this. I know a lot of people, including PHSO colleagues, want to support the NHS and do their bit to help healthcare workers at this time. From your perspective, what can people do to help?

Tony Dysart: I think what people can do to help is, obviously, using the health service responsibly, as I know most people do, but also using the health service. We aren't closed for business. We are still seeing patients who aren't suffering from COVID-19, who have got other problems, so it's just making sure that

you don't put things off, that you do seek appropriate medical advice, medical attention when you need it.

Then I guess the bottom line is just following the government's guidance, really. Staying at home is important. Not going out unnecessarily is vital. It does allow colleagues in the hospital to do the job that they're doing at the moment, so I think it's about using the NHS responsibly. It's about following the government's guidance on the lockdown, on staying at home and staying safe.

Rob Behrens: Tony, that was great. It's been an absolute pleasure to listen to you and to hear your experience. Thank you, everyone, for listening. Have a good and safe day.