LIFELINE

David A Grimes

David Grimes was professor and vice chair of obstetrics and gynaecology at the University of California, San Francisco. Jointly trained in obstetrics and gynaecology and in preventive medicine, he has studied the safety and efficacy of fertility regulation for a quarter of a century.

Who was your most influential teacher? Herbert Hazelman, my high-school band teacher, who taught me to choose a career that was fun.

Which patient has had most effect on your work? A young woman in Bangladesh with tetanus after having a stick stuck in her uterus. Watching her lie paralysed on a rubber sheet, I vowed never to allow politicians to drag women back to the "bad old days" of illegal abortion.

What would be your advice to a newly qualified doctor? First, decide early on whether you want medicine to be your life or your life's work. Second, don't trust anyone over 35 years of age. Or under 35, for that matter.

How do you relax? In a darkened movie theatre, with a box of popcorn, a carton of Milk Duds, and a Diet Coke.

What complementary therapies have you tried? Medical hypnosis, which has been useful in relaxing (between movies). I have not yet attempted to suspend myself between two chairs, however.

What is your favourite book? Bertrand Russell's *Skeptical Essays*, which I read in college: I became a convert to evidence-based medicine as a premedical student.

What is your favourite word? Gentamicin for sure. No other word in medicine is used so widely yet misspelled so consistently. A close runner-up would be "guaiac", one of those wonderful words, like "onomatopoeia" with four vowels in a row.

What is your worst habit? A victim of precocious toilet training, I am painfully compulsive—a useful trait in the operating theatre but decidely unwelcome at home.

JABS & JIBES

Being a patient is just the job

Choosing a colleague is fraught with difficulty, and it can be tough reaching a decision, especially when there is at first sight little difference between candidates. Even when they include extracurricular activities, the carefully prepared CVs are of dubious help. Does an interest in Himalayan trekking indicate an adventurous streak, or a propensity for taking lots of long holidays?

After the initial interview, further opportunities for appraisal arise at the "trial by sherry", especially when it's combined with "trial by spouse", but these, too, may fail to produce a clear front-runner. It's no wonder that some still favour the time-honoured method of throwing applications down the stairs. According to Galileo, these should all land at the same time, but members of appointments committees maintain otherwise.

One or two of my colleagues seem to be pioneering more novel techniques for seeking practice partners. So, on the basis of my recent experience, I reckon that any candidate who wants to have the edge could do worse than heed the advice of those who think every doctor should be a patient.

It is advice that medics rarely take, consulting other doctors only when they can no longer put it off. But the sick role can have unexpected perks, as I realised recently when my bunch of grapes brought me a plum job. Without going into extraneous detail, I can tell you that immediately after the proctoscopy, my general practitioner (GP) asked whether I would be interested in a tour of his new premises sometime, and what was I doing that afternoon? Thus, still clutching my prescription for ointment, I admired the brand-new building and agreed that the consulting-room overlooking the high street would do very nicely.

The rest of the selection process was reasonably orthodox and it only occurred to me much later that this was the third time I had obtained work by virtue of being a patient of a practice. On a previous occasion, one of the doctors where I had been registered had written to me out of the blue, inviting me to apply for a vacancy. At another practice, not long afterwards, my GP offered me a part-time assistantship, apparently on the basis of the clinical acumen I had displayed during consultations.

This may sound a pretty silly method of assessment, but it is no more random or senseless than any other and offers both parties interesting insights. From the candidate's point of view, being a patient gives one the chance of finding out the sort of doctors one could be working with. Naturally any symptoms need to be mentioned at an appropriate moment, preferably as part of one's preliminary recce. The pre-interview creep can be a difficult time, but a few well-chosen complaints will help dispel any awkwardness.

Before that all-important consultation, prepare what you will say. Ideally you will have a pulsating abdominal mass, flashing lights, a breast lump, or perhaps diabetes. These are the sort of symptoms that help separate the sheep from the goats, and that will also allow you a lot longer than 6 minutes in the consulting room.

Whatever you do, be spontaneous, stick to the truth, and avoid relying on a prepared list. As a doctor, you already know the rules of engagement, so no mentioning new symptoms when your hand is on the door, and of course no dark glasses, no chewing gum, and no complaints about being kept waiting. The examination couch is medicine's equivalent of the casting couch, so floss your teeth after broccoli quiche and don't forget to wash your pits and bits. Good luck.

Carol Cooper