



TLC SHOWCASE

Liam Hughes

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Introduction to *Bodily Fluids*

Without TLC my book would never have been published. Sure, family or friends might have stumbled across the document on my laptop, but most would never finish the rambling 70,000 words providing little digestible entertainment other than my truly appalling spelling and randomly generated punctuation.

I started writing because my gorgeous wife told me to stop moaning about missing work and suggested I wrote some of the stories she had heard me bore people with, and so I did. Her assurance that it would be cathartic proved accurate. At no time during the stochastic first draft did I envisage a wide audience. I felt that one chapter about a patient I had met in my first year after qualification, was my best effort, so I asked a friend to read it. His review surprised me. Not only had he enjoyed it but also, he heard my voice in the prose and had enough emotional impact to make him cry.

Buoyed by this I sent the chapter to my very busy daughter who is a renowned literary translator. Her reply was unequivocal. The text required major editing and suggested I look TLC up on the net.

The website was easy to negotiate and the advice for new authors pertinent and slightly intimidating. I have taken more exams than most and being a coward, I envisaged metaphorical or actual red ink covering the manuscript were I to submit it, so I didn't. On discovering this my wife, who had no wish to see me moping around, submitted the document to them.

I cannot thank Karl French enough for his review. My writing style had some panache, and he thought the subject matter might appeal to a wider audience. He even hinted at the publication potential provided I was happy to undertake major surgery.

I hold strong opinions about subjects I have experience of, and or some expertise. My family were surprised that I unquestioningly followed all Karl's suggestions, thinking my ego might get in the way. I have no ego about my writing because I am an amateur and Karl a wise experienced professional.

I set about editing the document. I had only ever written one long document before, my 30,000-word thesis. There was no Word then and I therefore made few changes. With this document Word was obviously helpful but chopping and changing easily does have a downside. Not all changes improve the text or structure and sometimes

I would make changes in the morning, only to revert to the original in the afternoon. Progress was slow until once again my wife helped. I did not want to produce a chronological memoir. In my early drafts, remembering one patient would trigger a recollection of several others from that year. She pointed out that by grouping the stories according to the most relevant bodily fluid, would facilitate circumvent the chronological issue.

Armed with this, progress improved and although the second review by Karl still made it clear further work was required, as before I followed all his advice.

Thereafter I was told that for a medical memoir an agent would be required. For several weeks my emails would include replies stating that the market is very competitive and that various agents were unable to help. Disheartened, I decided to abolish any thoughts of publication. History repeated itself and my wife sent a chapter to Eyebooks, informing me after the deed, that we might get more disappointment in 12 weeks. We received a reply in 5 days asking for the full manuscript, and with further polishing by Simon Edge the book was released on February 5th 2026.

Extract from *Bodily Fluids*

Cirrhosis is a condition that affects the liver. The tissue becomes progressively scarred and, in many sufferers, causes death. In some the end is dramatic due to a combination of factors. Increased pressure in the veins within the lower oesophagus (gullet) makes them distend and sometimes rupture. In cirrhotic patients, the liver no longer produces the proteins that facilitate blood clotting, so any bleed is less likely to stop. Some patients lose litres and die within a few minutes.

Cirrhosis has many causes including excessive alcohol especially at a young age. This patient came from a family that delivered beer from a brewery. Tradition was that the drayman would have a pint at every pub on the round. This patient first accompanied their father aged eight. Initially only receiving half a pint, by early teens consumption had increased triggering the cirrhotic process. Their consumption was relatively modest, but their vulnerable liver inexorably deteriorated and by late teens the prognosis was very poor. In that era transplantation was not an option.

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When I was called urgently to the ward, I knew who was in trouble. The patient was sitting upright, staring at his family repeating the phrase, 'Something's happening – I'm going to die.' I have since seen this behaviour in several patients, but the absolute certainty and almost matter-of-fact way in which this was stated, left me in no doubt that the patient was correct.

With help from the nursing staff, I managed to clear the room and ask that my registrar be summoned. Even before the tell-tale gurgling, and before black coffee-grounds and fresh blood trickled from the side of the patient's mouth, I had opened up the drip and ordered blood transfusions.

By the time the cavalry arrived, the trickle had become a torrent and, with every gasp, a plume of blood arched across the bed. The registrar, who was very experienced and wise, immediately ordered an industrial dose of diamorphine (usually used with extreme caution in patients with cirrhosis). This was possibly my first experience of a competent and humane doctor going outside guidelines to better serve the patient's needs.

We tried to deliver a special tube which could be positioned in the lower oesophagus to compress the bleeding veins, but such was the torrent of blood that this was

impossible. This rubber device, which would not have looked out of place in a sex shop, added to the grotesqueness of the scene.

We could hear the growing anguish of the family, who were desperate to know what was happening. The patient was unconscious and, rightly or wrongly, we decided the family should not witness their loved one in such a horrible state. I received a second important lesson about the reality of medical practice. The patient was dying, but the family would want to know that everything possible had been done.

As Sister cleaned the patient and changed the soiled bed linen, my registrar declared that this was a two-cigarette resuscitation. During the ten minutes he smoked his Piccadilly tipped, carefully blowing the smoke out of the window, he delivered a tutorial on the realities of resuscitation. His technical advice on delivering large central line drips proved invaluable over the next 40 years. His thoughts on when, and when not, to discontinue resuscitation brought perspective to the existing didactic protocols. Lastly, he emphasised the importance of always personally speaking with the family of patients who die suddenly and dramatically, a responsibility that never left me.

When the patient had been cleaned, the registrar pointed out that I knew both the family and patient better than him, and it was therefore my duty to deliver the sad news. I was flattered and nervous in equal measure.

There are many euphemisms for death, or more precisely the transition from being alive to being dead. I have learned that understandably distressed, desperate, frightened, shocked and sometimes hysterical relatives, will often misinterpret softer terms such as 'gone', 'lost' or 'passed'. The words 'died' or 'dead' must be used to avoid any confusion, but they must be delivered with compassion and, in sudden cases, with the assurance – even when it wasn't true – that their relative had suffered no pain or distress.

I will never forget the anguish, perhaps driven by guilt, on the father's face. I was grateful for his intervention when some of the younger males of the family threatened the bearer of the tragic news with violence.

About the Writer

Liam Hughes worked as a hospital doctor from 1979 until 2023, when he retired aged 70 years. Unusually for a doctor he left school with no science A-levels and was due to matriculate at Cambridge to read geography (and play as much sport as possible), when without warning medicine called him.

To the surprise of almost everyone, he gave up his place despite knowing that enrolling in medical school would be difficult. He worked as a hospital porter, lumberjack, lorry driver and waiter for several years before being



accepted to Guy's in 1973 on their pre-medical first MB course. This course is no longer offered and was an historical 19th century facility for school leavers with classics such as Latin and Greek, rather than science.

After qualifying he spent 14 years as a junior now re-branded resident, gaining further degrees including MRCP and a doctoral thesis as well as broad training in all aspects of cardiology. He was appointed cardiologist at Norwich and Papworth hospitals.

He helped to introduce the “heart attack” service in Norfolk which required a significant charitable supplement to help the cash strapped NHS. As one of the charity founders, for publicity, he rowed the Atlantic.

His maverick personality often put him at odds with management, but his love of clinical work, especially the emergency treatment of patients suffering a heart attack never wavered. Getting up in the middle of the night with the diverse on-call team, reminded him of the esprit de corps of his sporting youth.

An opportunity to support a similar service in New Zealand presented itself in 2015. Initially taking a sabbatical he decided to stay because there was more medicine and less politics. He finished his career at the regional hospital in Wellington.

He returned to Europe in 2023 to be nearer family. Living close to Cognac with his wife and two large hounds, he enjoys walking, watching the local rugby side and the food.