

HASLAM'S VIEW



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GPs not working fast enough for local PCT

I RECEIVED AN INTRIGUING EMAIL FROM A GP COLLEAGUE JUST A FEW DAYS AGO.

He was working in a deprived inner-city practice area, with a huge list, and 95% of patients needing an interpreter for the consultation. The contrast with an area like mine, where about one in a thousand patients needs an interpreter couldn't be greater.

Although I sometimes think my patients would benefit from someone who could translate medical English into real English – particularly when they receive copies of letters sent by a few of the local consultants.

But that's not the story. The reason for the email wasn't language or ethnicity, but the fact that his local PCT had decreed that GPs weren't working fast enough. Because of the cost pressures on the health service and the nation, and the increasing shift of care from hospitals to primary care, the PCT felt that the solution was simple. If GPs worked quicker, then they could do more work and the world would be a better place. My colleague wanted to know what I thought.

I'll tell you what I think. I'm appalled and simultaneously astonished and not in the least surprised. I'm astonished that anyone can still have such a naive view of what it is that GPs do, and not in the least surprised that there are people who have been led to believe that what we do is simple.

It's difficult to underestimate the magnitude of the error that this PCT is making. After all, if you haven't got time to sort a problem out safely, are you more or less likely to make a referral for a specialist opinion? By undervaluing, and failing to understand and support the complexity of our work, referrals and costs will go up – not down.

'The PCT felt that the solution was simple. If GPs worked quicker, then they could do more work'

I seem to spend my life going on and on about the complexity of modern general practice, but that's probably because the cases I see seem to be more and more difficult to unravel, and I'm finding that I need much longer consultations to get through the work. I'm also aware that this could be because I'm simply slowing down with age, but my younger partners assure me that they find exactly the same problem.

So what's going on? I think it's relatively simple. Compared with practice earlier in my career, more and more patients are surviving or avoiding major illness. I rarely seem to see most of the acute medical and surgical emergencies that characterised the start of my career. Instead I see people who are on a vast number of medications, for a

mass of complex long-term conditions. And their needs and questions and consultations are incredibly difficult.

Yesterday morning I saw a patient who has chronic kidney disease, Barrett's oesophagus, migraine, hypertension, and dreadful osteoarthritis. Her simple painkillers aren't working, and she wanted my help? The only drugs that had ever helped her were NSAIDs, and she was pleading with me to prescribe these. As she said, simply, 'It's my body. I'll take the risk.'

Now, this wasn't the stem to a complex examination question. It was the closing part of a consultation about her mother whose dementia is deteriorating. It was typical general practice. And it's incredibly difficult. Almost every therapeutic option had a significant disadvantage. And her psychological and emotional needs – I forgot to mention her depression – needed addressing too.

So if my PCT wants me to deal with my patients any quicker, for the simple sake of some ludicrous concept of efficiency and value, the answer will be a simple one. If somewhat anatomically challenging.

Tell us what you think?

Have you had a similar experience with your PCT? Write to:

editor@thepractitioner.co.uk