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If we want to keep our NHS, we need an alliance between GPs and patients

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GPs are campaigning to rebuild general practice.

To succeed, and to keep the NHS as a service for everyone, available when called upon and free at the point of delivery, they must gain the support of patients.

But the campaigners don't seem to have a sense of the place of patients within the power structure of primary care.

GPs must reassess their communications with and obligations towards patients, and the role they offer to patient participation groups.

The background

As we all know, the Covid-19 pandemic has put the NHS under huge pressure. Ambulances queueing outside hospital emergency departments are a common sight, while a backlog of more than 6,000 people in England are now waiting for supposedly non-urgent treatments like knee, hip and cataract operations. Less conspicuous is the workforce crisis that now exists in the primary care sector of the NHS, among general practitioners (GPs), our family doctors.

On 21 March 2022, GPs from across England, Scotland and Wales launched a campaign to [Rebuild General Practice](#) (RGP). Supported by the British Medical Association and the General Practice Defence Fund, its leaders argue that General Practice is in crisis, and patient safety is at risk. They say:

Demand for GP appointments is outstripping supply. There are simply not enough GPs. Patients should be able to consult their GP when needed. GPs want to deliver this, but the system is in crisis.

Although GPs are delivering more appointments than ever before, retirement and 'burnout' of GPs, coupled with growing patient demands, are creating what the campaigners describe as an unsafe and unmanageable situation for primary care.

This is highlighted by the most recent [British Social Attitudes Survey](#), published in late March 2022. It found that from 2019 to 2021, satisfaction with GP services fell by a remarkable 30 percentage points, from 68 per cent satisfied to 38 per cent.

This is the lowest level recorded since the survey began in 1983. The previous lowest figure recorded was 63 per cent in 2018.

In 2019, the UK Government promised to deliver a workforce plan for General Practice and the NHS in England. In March 2022, it has still not materialized. The situation in NHS hospitals gives us some idea of where the Government is heading. It has recently transpired that [official draft guidance](#) from NHS England (NHSE) is encouraging NHS trusts to grow their 'private patient opportunities', despite facing huge backlogs of NHS work.

If the Government and NHSE stick to this position, we can expect more and more private sector initiatives in the field of primary care too, such as private companies setting up health centres where GPs work as employees, rather than partners as most are now.

GPs, their workload, and the healthcare political structure

As for GPs' workload, Fisher and others have pointed out in a recently-published [analysis of policies to improve general practice in deprived areas since 1990](#), that there are more GP consultations per week or month now than there were before the pandemic,

but the number of permanent, fully qualified GPs has fallen since 2015. The pandemic has created additional work for GPs, such as delivering millions of COVID-19 vaccinations, and there is a major backlog of unmet health care needs. GPs are also under pressure from government and national NHS bodies to increase [the number of] face-to-face appointments – and risk being 'named and shamed' for not doing so. Staff are exhausted ...

The reference to GPs being 'under pressure from government and national NHS bodies' and risking being 'named and shamed' draws our attention to the important fact that the health care system in England is a 'power structure', the component parts of which are linked by communication channels and levers, links of obligation through which pressure can be brought to bear.

It is through communication channels, of course, that information, the 'lifeblood of decisions' flows. To be cut off from sources of information is to be powerless to influence decisions. As for levers, these come in a variety of forms. Some are enshrined in contracts; some stem from a sense of vocation or feelings of duty; others take the form of political levers pulled by others: 'do what we ask, or else'.

There is of course a connection between communication channels and levers: a particularly important lever is the duty to consult, which has been enshrined in GPs' contracts since 2015 in the form of the requirement to set up a patient participation group (PPG) in every practice.

Doctor-patient relationships: the GPs' view

How do GPs perceive the power structure as it affects themselves and patients? A recent publication by the Royal College of General Practitioners (RCGP), [*The power of relationships: what is relationship-based care and why is it important?*](#), provide some insight. In his foreword, Professor Martin Marshall, Chair of the RCGP, wrote:

Covid-19 has radically changed the face of general practice. We have moved from a predominantly face-to-face service to one in which most consultations are delivered remotely, either by telephone or video call. ...

Remote consultations are certainly here to stay. For many patients, they enable quicker and more convenient access to a GP appointment... [But what] about the quality of care? What about the relationship between doctor and patients which, to me, is the essence of general practice?

For many of us, delivering one remote consultation after another has felt very transactional. The phrase 'call-centre medicine' springs to mind. And I fear that a predominantly remote service is ultimately to the detriment of relationship-based care ...

Professor Marshall argues that 'the relational dimensions of care are ... no less important than convenience'. He points to 'compelling evidence' for the benefits of trusting relationships: these include better patient experience, better adherence to medical advice, fewer prescriptions, better health outcomes, better job satisfaction for doctors and even fewer deaths. This will be particularly true for chronic conditions but also for children and the elderly, where subtle changes in development or decline may be missed if there is no ongoing relationship.

What Professor Marshall doesn't say is as interesting as what he does. He says the RCGP plans 'to engage policy makers, health experts and primary care practitioners to identify what change levers are needed to strengthen relationship-based care so that it remains relevant in the modern primary care landscape'. Notice that patients aren't on this little list of people to be engaged.

Other writers, such as Coulter and Oldham, in their paper [Person-centred care: what is it and how do we get there?](#), do emphasize the principle that patients should be treated as equal partners in the business of healing. They are at least implicitly recognizing the power structure in the world of healthcare. Doctors campaigning for reform seem not to be doing that as yet.

How does the healthcare power structure work at grassroots level?

To see how the healthcare power structure works at grassroots level, and how it might be improved along 'alliance' lines, we can examine two issues that are to do with the way that a practice works, and a third that crosses practices and is to do with how widely available in an area a particular service is: three case-studies in all:

- The frustrated desire of a number of patients to be seen and treated by *their* GP, which happens to accord with the principle of continuity of care, but because of pressure on GPs' time may not be given priority;
- The policy in some GPs' practices of encouraging reception staff to regard their task as one of protecting doctors from patients, which has inflamed hostility rather than making and preserving peace;
- The frustrated desire of many patients, especially those who are elderly, for the continued availability at their GP's practice of much-valued but precariously commissioned services, such as that for removing earwax, a service which has been withdrawn from many practices.

Patients' desire for continuity of care

When there is pressure on doctors' time and on the funds at their disposal, it is hard for them to give a patient the attention that they or the patient or both would wish. To deal with these pressures, practices have introduced or stepped up their use of remote communications – phone, email, etc. – which many patients have found helpful and time-saving, especially for minor or recurring complaints.

But some practices have resorted to rationing devices of one kind or another. These have included the 'cab rank' rule that a patient cannot expect to see 'their' doctor and has to see whoever is available. Or the patient has been told 'we are a team now', the corollary being that there is no longer any such person as 'your' doctor, and that someone other than a doctor will decide which staff member they should see. Some practices have instituted a rule that a patient can have only a single medical complaint attended to at an appointment.

All such devices are liable to upset patients if they encounter them for the first time when seeking an appointment with their doctor.

Communication channels The failure to consult patients in advance or even warn them once a decision has been taken reflects the absence of a channel of communication by which this might have been done. Not giving them an opportunity to express a view when new arrangements are introduced is again to deprive them of a communication channel. If continuity of care by *their* doctor is to be the norm, there needs to be a two-way communication channel between doctor and patient.

Continuity of care is an important element of what Professor Marshall describes as relationship-based care. As he puts it, it means knowing your patients, understanding their health issues in the context of their lives, forging a bond of understanding, trust and empathy.

Such a bond clearly has a dimension of communication, as does 'better adherence to medical advice'. We might add that a communication channel providing knowledge of the patient's medical history and background, such as their housing, employment and family circumstances, will enable a GP who gets a request for an urgent appointment from a patient to judge whether the request fits into a pattern, such as the worsening of a previously treated condition, or indicates a new development, perhaps calling for emergency treatment.

Again, if the patient presents at a hospital's emergency department, it could be very helpful if the clinician assessing them can call their GP to get a fuller understanding of the patient's circumstances. And when a patient is pronounced medically fit for discharge from an acute hospital, the GP will be aware of their home circumstances and able to contribute usefully to decisions about facilitating their discharge.

Levers Everything that Professor Marshall describes demonstrates that he feels *responsibility* towards his patients. He is acknowledging and accepting an obligation to play his part in creating that 'bond of understanding, trust and empathy'. And a patient who asks to see *their* doctor is acknowledging that bond. If there is no continuity of care, doctor-patient communication may be perfunctory. Much will depend on the quality of the notes that the doctors keep following appointments: under pressure of time these are bound to be written in haste.

The role of GPs' receptionists

Receptionists in GP practices occupy a crucial 'gate-keeping' role. Some receptionists are extraordinarily good at their job. They are empathetic, skilled at putting patients at their ease. They have a sense of where a patient draws the line at providing intimate details to someone who is not a doctor or nurse. They know it is not their role to diagnose. But they are able to judge accurately whether the person a patient should see is a nurse practitioner or the GP, say, and able to explain why in a way that is not patronising.

Other receptionists are not so gifted. There are some who learn to interpret their job specification as being to protect 'their' doctors. So their role becomes akin to that of the school prefect, exerting discipline on the unruly demanding mob of junior children at their door. They can make the experience of seeking help from one's GP a stressful and humiliating one.

The atmosphere that this engenders is one of hostility on both sides, with some patients left feeling that their GP is not giving them priority or even their full attention. Sometimes, especially in the stressful, traumatising and frustrating circumstances of the Covid-19 pandemic, this has led to anger and abuse directed towards doctors and reception staff.

As far back as 2006 the British Medical Journal (BMJ) carried sensible and sensitive advice on [dealing with angry and aggressive patients](#) (its four sections are headed Causes of anger, Warning bells, Do's, and Don'ts). However, the Institute of General Practice Management cannot have helped matters by publishing recently a campaigning video entitled [If I die it will be your fault](#). It has received more than 250,000 views, some of them through having been reposted on practices' own websites. It consists of a set of clips of abusive and threatening statements said to have been uttered by patients towards reception staff. In essence, it categorizes patients as potential sources of anger and threats, and sadly the Institute's website offers reception staff no helpful advice whatever on dealing with them. Showing such extreme behaviour in a video can only raise hackles to little purpose.

Communication channels What we see here are the limitations of communication channels in both directions. Practices publish on their websites warnings to patients of the 'We will not tolerate ...' variety, while there is rarely a channel through which patients can provide relevant information about their situation,

such as why and how their current medical condition, or that of a member of their family, is causing them stress.

What should be helpful would be for practices to provide *explanation and guidance* about how their system works: on what principles it is based, how priority of need is determined, what a patient can do if all appointments for the day have been booked, how to access the nearest minor injury unit or urgent treatment centre. Such information, preferably available both in leaflet form and on the practice's website, and reviewed in the light of feedback from patients, should also reassure patients that their needs are being thought about.

Practices should also facilitate communication *from* patients. If they invite patients who are stressed to let the practice know, via text or email or on paper, about the difficulty they have experienced in getting through and making their situation known, and if they undertake to reply, this would show understanding on the part of practice staff about the stress that patients are under and provide patients with an opportunity to 'let off steam' in a more considered and thoughtful way. It is crucial in any case to provide communication channels that enable *dialogue* between practice and patients

Levers When communication channels between practice and patients are poor or non-existent, with patients feeling that the gatekeeper is tasked with fending them off rather than facilitating access, levers available to patients will be correspondingly conspicuous by their absence. Willingness to listen on the part of reception staff can and should be part of the whole ethos of the practice. Indeed, the obligation that Professor Marshall feels under to help create that 'bond of understanding, trust and empathy' between doctor and patient is an obligation that should extend to all reception staff. They all have a part to play in creating that bond. Without it, and without the continuity of care that should accompany it, communications between practice and patients risk becoming superficial and the practice risks becoming nothing more than a medical care 'shop'.

It is for GPs to ensure that their reception staff possess the human skills that their job requires, to keep an eye on how they do their job, and to ensure that training is available to keep them up to date. Experienced reception staff are professionals and should be treated as such.

Maintaining earwax removal treatment in GPs' practices

In the past and in most areas of the country, people whose ears have become

blocked with wax have been able to go to their GPs for the necessary treatment, known as 'syrringing'. (This procedure has been superseded in recent years by 'irrigation' and more recently by 'microsuction', which is safest.) Patients are now discovering, when asking for this service, that it has been withdrawn.

In Cornwall, for example, a 2019 survey found that only two practices in the Duchy were not offering earwax removal. A year later, a survey of 15 practices found that nine were not offering a service 'at present', five were offering only a limited service on a case-by-case basis, and just one was offering the microsuction service. Some practices were directing patients to private, fee-charging providers. This is a striking example of how services can get removed with no prior impact assessment nor consultation with patients.

Perhaps understandably, the earwax removal issue, which was first raised two years ago, has not been uppermost in doctors' minds during the Covid-19 pandemic, but more recently some GP practices refusing the service have been saying that earwax treatment had 'never been in the GP contract'. Some patients have had to travel long distances and pay privately for treatment; some have been going without.

Losing your hearing is highly distressing and seriously inhibits your ability to participate in society. The former chairman of Cornwall's clinical commissioning group claimed that an aim underlying all its policies was to provide reablement, but doing nothing to stave off people's hearing loss is a policy that amounts to *disabling* them.

How might this situation have been avoided?

Communication channels In the first place, there should have been fact-finding, communication between doctors (both GPs and doctor members of the clinical commissioning group) and patients, to discover how many patients were asking for and in need of earwax removal treatment. Reception staff should have been asked to keep a record of those numbers. In practice, no thought appears to have been given to establishing a communication channel through which patients could say what their experiences were, how they were coping with the new setup, and what they thought about it.

Levers But that communication channel on its own would not have been enough. There should have been at the very least a sense of obligation on the part of the GPs to consult patients before deciding to dispense with the previous earwax

treatment policy, to tell them what was being considered and what the reasoning behind a possible change was, and to ask how the change would affect them and what alternatives they could suggest. (These might have included continuing to make the treatment available at just a proportion of the practices in their locality.) Such a sense of obligation was evidently absent.

The consequence of this absence was that patients were compelled to go into campaigning mode to overturn decisions already taken behind their backs. Thus the GPs forced patients to become their adversaries instead of their allies. They also put themselves into a defensive position, seeking to justify decisions that they had already taken.

We don't know what discussions took place before the service was suspended, so we don't know whether any GPs did feel an obligation to at least speak up for patients who would lose it. But it has emerged that one line of argument was that maintaining the service would impose heavy demands on a limited workforce and that there was a 'finite' budget: we don't know of any decision-maker suggesting that it would be sensible to measure the need for this service, which might have counter-balanced those considerations.

What role for patient participation groups?

Since 2015 GPs' contracts with NHS England require all practices in England to have a Patient Participation Group (PPG). They must make reasonable efforts for it to be representative of the population which the practice serves.

A [best practice guide for PPGs](#) has been produced by Healthwatch Central West London. It says that in partnership with the practice, the PPG should aim:

1. To act as an advisory group providing perspectives and concerns from patients that can influence how services operate at the practice
2. To communicate to the practice areas of patient concern with a view to influencing change
3. To act as a consultative group for any changes at the practice
4. To encourage and support the role of the practice in involving patients in their own care
5. To monitor complaints and comments received about the practice
6. To annually review the results of the patient survey and suggest changes as appropriate.

What do these six objectives tell us, albeit implicitly, about communication channels and links of obligation?

Communication channels Objective 1 implies that the PPG must be provided with information about how services are operating, while Objective 2 manifestly requires the practice to listen to what the PPG says about identified needs for change. Objective 3 implies that there should be a recognized consultation procedure, while Objective 4 implies that the practice should tell the PPG how it sees its role in involving patients in their own care. Objective 5 implies that the practice should tell the PPG about complaints and comments it has received, while Objective 6 makes clear that the practice must pass the results of the patient survey to the PPG and any suggestions for change must be listened to.

As we can see, the implication for communication channels of these six objectives is that practice members and patients are very much on equal terms. Many patients will have had longer experiences of the NHS to draw on than the doctors and other practice staff who are caring for them. There is a reservoir of knowledge here from which practices could usefully profit.

Levers As we can also see, all six of the above objectives place obligations on practices: to supply information to the members of the PPG and listen to the responses they receive. But the objectives are worded very gently: the language avoids spelling out that doctors and other practice staff have *duties* towards patients.

GPs' attitudes towards patients

The three case studies and the PPG model objectives all make clear that at the heart of doctor-patient relations are communication channels and levers by which patients can bring to bear pressure on doctors in the course of taking decisions about how the practice should function. Doctors' and patients' organizations alike seem reluctant to discuss their relationships in these specific terms, as if it were impolite to mention that the decision takers should be *accountable* to patients, under a *duty* to heed their views and to give reasons for going against them.

This raises a question about the *attitudes* of GPs towards their patients. We can get clues about these by examining how they treat their PPGs.

- Ideally the practice's senior GP would attend PPG meetings, but in some practices the task may be delegated to a junior.

- Ideally the meetings will be chaired by the elected chairperson of the PPG, but it has been known for it to be left to the practice manager to chair them.
- Ideally PPG members will be provided with the written reports that practice members (presumably) receive so they are aware of the issues that are currently concerning the practice, but this seems to be rare.
- Ideally PPG members will be equipped with the means of consulting all the patients registered with the practice – by circulating a questionnaire, for example.
- Ideally arrangements will be made for patients who cannot physically get to PPG meetings to participate via Zoom or MS Teams.

Integrating Additional Roles into General Practices

A recent innovation in primary care has been the grouping of GP practices into primary care networks (PCNs), alongside a scheme set up in 2019 to support the recruitment by PCNs of 26,000 additional staff working in general practice by 2023/24. An evaluation of the Additional Roles Reimbursement Scheme (ARRS) was [published by the King's Fund](#) in February 2022.

The 13 additional roles included clinical pharmacists, first-contact physiotherapists, social prescribing link workers and paramedics. Although employed by PCNs, they are based individually in practices' premises, on the principle that this will assist the development of multi-disciplinary teams within and across practices.

The King's Fund evaluation concluded:

The cultural change required by the introduction of additional roles, and new approaches to teamworking, requires extensive organisational development, leadership and service redesign expertise and this has not been adequately available to PCNs, nor is it present in many individual practices. All of this has been compounded by the impact of the Covid-19 pandemic on general practice.

While PCNs and practices are sorting themselves out, there could be a role here for PPGs. For example, they could meet and welcome people in additional roles when they join the practice, and they could inspect the practice's web pages to see whether adequate information about them is presented. A page on 'Our Staff' that has them at the very bottom, below medical secretaries, that provides no

photographs, and that fails to say what the social prescriber actually does or that the physiotherapist's role is, as a first contact, to diagnose but not to provide treatment, is manifestly inadequate.

PPGs should also form themselves into networks, mirroring PCNs, enabling members to meet and learn from each others' experiences, and feeding back to their own practice and to the PCN.

To sum up: At a time when the very future of general practice within the NHS is up for discussion, there needs to be a frank examination of what patients can contribute to doctor-patient relationships, with no presumption that GPs are accountable to patients only insofar as they diagnose, prescribe and refer.

Otherwise we shall continue to have GPs focused on defending their currently privileged status while patients who can afford it vote with their feet for a health service that gives them what they want, when they want it, even if it has to be paid for. If GPs want to think of themselves as participating in trusting relationships with patients, to quote Professor Marshall, they must accept that the structure of primary healthcare in the NHS, with its communication channels and levers, and their demands for accountability, includes patients too.

When the GPs' campaign to rebuild general practice was launched, the RCGP issued a manifesto proposing five priority actions for government to take to improve the care for patients in general practice. Their campaign will be all the more persuasive if they can show that patients are on their side.