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Patient perspective

What will happen to personal care under the new General Medical Services contract for GPs in the UK?

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For some time there has been a widely held view amongst doctors and other professionals that the current General Medical Services (GMS) contract for general practitioners (GPs) has outlived its purpose. While the new GMS contract for GPs may address many of the concerns held by GPs, there are aspects in the contract that raise considerable concerns for patients.[1] In future, patients will register with a practice rather than an individual doctor. Does this herald the end of personal doctoring and long-term care given by a doctor whom the patient gets to know and who knows the patient and their circumstances? Or will the new contract encourage better integration of patient care as 'holistic care will be incentivised through holistic care payments under the quality framework'? Gordon Moore asks whether general practice will be able to achieve these targets and how it will be done and he cites René Dubos' warning that 'sometimes the more measurable drives out the most important'.[2]

Patients and their carers want a high quality service with the opportunity to share in decisions about their own health and a bigger say in how they are treated.[3] In some areas, for example The Expert Patient Programme, this has already been acknowledged.[4] But involving patients in their care, sharing decisions with them and encouraging patients to be able to take decisions and be involved requires at least some of the following:

- skill and time on the part of professionals
- willingness on the part of both professionals and patients
- good communication between professionals.

One of the features of contemporary primary care is its interdisciplinary nature. Within general practice there is an increasing role for receptionists who are not only involved in different tasks in the administration of the practice, but play an active role in patient contact in informing patients of results, asking patients to make appointments and giving patients a message that for example there is a prescription to collect. In addition, receptionists have regular patient contact in the making of appointments and responding to general queries. From the patient perspective there are clearly advantages when the practice has efficient staff who can answer queries and give appropriate information.

However, recent personal experience showed that it was not uncommon for a receptionist to phone the home of a frail elderly and housebound patient to say that there was a prescription to be collected. When this was an unexpected event and there had been no other communication from the practice it was not unreasonable for the carer to inquire what the prescription was, what it was for and why it had been prescribed. Good practice would suggest that in these circumstances the receptionist should have been briefed by the practitioner to give sufficient and appropriate information to the carer. There is an opportunity for good use of delegation, saving of the practitioner's time as well as an opportunity for receptionist staff to build a relationship with the carer. Sadly the experiences were that the carer was informed that these questions could only be answered by doctors who were not necessarily available.

From the patient perspective, one of the arguments in favour of personal doctoring, and perhaps also an argument in favour of smaller practices, is that receptionists can get to know patients. It is appreciated that in larger practices with big lists and many receptionists, several of whom may work part time, it is not possible for reception staff to know all patients. However, computer systems allow for an identifier to be put against the name of patients with particular needs. It is therefore quite unnecessary for the carer of the housebound frail elderly patient requesting a home visit to be asked why the patient cannot be brought to the practice. For the practice this may seem a minor omission. For the patient, who had been a patient of the practice for many years and their carer, it was extraordinary and emphasised the isolation of an already vulnerable person.

There has also been a very considerable expansion in the role of nurses who run many clinics within practices, are involved in the management of chronic

disease, may prescribe and some, including the district nurses, carry out procedures previously done only by medical practitioners. Some nurses may be employed directly by individual practices while others are employed by the primary care trust and work for several practices. This is relevant to nurses acquiring up-to-date information about the situation of a particular patient. Few district nurses have laptop computers and may only be visiting the practice once or twice a day. Furthermore, district nurses work in teams thus emphasising the importance of regular communications between members of the district nursing team, between nurses and GPs, between different practitioners involved in the care of the patient and of course the patient and their carer.

District nurses visiting on a regular basis leave nursing notes with the patient, which are kept up to date. These notes relate to procedures that the nurses have been concerned with. The patient may have other health problems not dealt with by nursing staff and may be on multiple medication not necessarily detailed in these notes. There is a tendency for district nurses to be concerned only with symptoms of the problem that they are treating. This is not a holistic approach.

Carers are not diagnosticians and most are not qualified nurses, and yet they have to be alert to situations when medical intervention is required. Caring for the frail elderly at home requires an integrated approach which should be led by a doctor or at least have considerable medical input.

GPs cannot always assume that district nurses concerned about particular aspects of the patient's healthcare, will be alert to other problems that may be arising. Nurses may not be aware of problems caused by the side effects of medication and they may not have regular access to the medical records of the patient.

The examples of the need for integrated holistic care have focused on receptionists and district nurses and are based on a situation where there was a personal list. But even in the situation where the GP knows the patient, it is not always possible to provide such care. It is very difficult to see how the new contract will improve the situation. Who in the practice will be taking responsibility for the care of the patient and how will the patient and other professionals involved in the care of the patient know who this is?

The need for integrated, holistic care is particularly important for the frail elderly as well as those who have chronic conditions. It is pleasing to note that this view is supported by the Royal College of General Practitioners in their comment on the draft new General Medical Services contract.[5] Quality in primary care requires integrated, holistic care of patients being cared for in the community. It is hoped that changes in the GMS contract do not make it more difficult to achieve this and that Dubos' warning does not come to pass.

REFERENCES

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CONFLICTS OF INTEREST

None.

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