Editorials

Safety netting:

now doctors need it too

INTRODUCTION

'Risk', said the billionaire philanthropist Warren Buffett, *'comes from not knowing what you're doing.'*

I don't think many surgeons would agree. In their line of work, risk is inescapable, no matter how sure they are of what they're doing. But Buffett's epigram is at least in part true in general practice. One of the defining hallmarks of our discipline is managing the uncertainty that goes with the complex interrelatedness of our patients' problems. We pride ourselves on what Aristotle called 'phronesis', namely 'flying by the seat of our pants', or 'knowing what to do when no one knows what to do'. A diagnosis in general practice, rather than a label for what a patient's condition *is*, is just as likely to be a list of what it might later *turn out* to be. And there is no shame in a general practice management plan often being just what seems, on the day, to be the best thing to do under the circumstances. But with clinical doubt comes a duty to take precautions.

THE THREE 'THINKING AHEAD' QUESTIONS

It is now over 30 years since I introduced the notion of safety netting to describe the risk management and contingency planning I thought should be present in every general practice consultation.[1] What I had in mind at the time was summarised in the three 'thinking ahead' questions I suggested we should ask ourselves before concluding any consultation:

- If I'm right, what do I expect to happen?
- How will I know if it doesn't?
- What would I do then?

It is a personal satisfaction to me that safety netting has become generally accepted as an element of good practice. It features, for instance, in the National Institute for Health and Care Excellence guidelines for the early recognition of cancer,[2] childhood fevers,[3] and meningitis.[4] However, firm evidence of its benefits is hard to come by. A Belgian study of safety netting in sick children,[5] for example, found that most GPs safety netted 'intuitively' but with little consensus about when and how to do it, the authors reaching the seemingly inevitable conclusion that, in order to assess its effectiveness, more research is needed. But is it really?

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We shouldn't need double-blind trials to convince us that motherhood is a good thing and apple pie is tasty. And it would be a shame if the outcome of such further research were to be a list of recommended safety-netting interventions, categorised according to clinical scenario, and adding yet another box to tick in pursuit of the mythical perfect consultation.

I've always thought of safety netting not so much as a strategy or technique but more a matter of mindset, analogous to the 'precautionary principle' widely incorporated into many areas of international policy, and even — dare one mention it? — enshrined in European Union law.[6] Get the habit of thinking 'What if ...?' firmly established in the clinician's mind, I believe, and safety nets almost create themselves, appropriately individualised and contextualised as each patient requires.

One virtue of seeding an idea like safety netting into the mind in an unfinished form is that, like a grain of sand in an oyster, it can niggle something unexpected and valuable into existence. The paper by Hirst and Lim,[7] where they describe using text messaging to follow up patients who presented with possible cancer symptoms, is an example. By hitching a common clinical anxiety to a popular technology, they have created an innovation that 'early adopter' GPs will enjoy developing, and that will probably save some lives.

Until relatively recently, the party most at risk from how general practice is conducted, and therefore the focus of safety netting, was the patient. But things have changed. GPs themselves are now increasingly imperilled by their working conditions. Rising expectations and workload, combined with worsening shortages of time, staffing, and resources, pose such a threat to good practice that GPs, both individually and collectively, need some safety netting on their own behalf, something to rescue them should they start to wilt under the strain.

For some fortunate individuals, their own idealism and satisfaction in the human worth of their work acts as a sufficient safeguard. But others may find the need for self-protection pressuring them towards some maladaptive responses: a retreat into a dogmatic 'doctor and the guidelines know best' style of consulting; a defensive tendency to over-investigate and over-treat; a cynical mistrust of the motives of patients and policymakers alike; and premature retirement.

SAFETY NETTING — NOT JUST FOR PATIENTS

'At scale' is today's buzz phrase. Schumacher[8] was wrong, apparently — it's big, not small, that is beautiful now. Every good idea, including safety netting, has to be implemented 'at scale'. So let me scale up my three original questions, and put them to the profession as a whole.

What is general practice entitled to expect? We expect to work within a social contract whereby we undertake to serve the interests of our patients as best we can, in exchange for the necessary time, personnel, tools, facilities, and back-up being available. We expect our professional values to be respected and endorsed — or at least not actively sabotaged — by the state organisation that employs us.

How shall we know if it isn't working? That's easy. Note the recent British Social Attitudes survey, showing patient satisfaction with GP services at a 35-year

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low. Count the thousands of unfilled practice vacancies. Look at the soul-destroying recruitment and retention figures. Observe how, with every fresh reconfiguration of the NHS, care becomes less something we do and more a commodity to be mass produced and traded *à la* Sainsbury's.

So what is to be done? When in the consultation the patient is at risk, the onus is on the doctor to take protective action. When the positions are reversed and it is we doctors who are in danger, we must look to our patients — or voters, as they become every few years — for help. In this, our professional organisations are already on the front foot. In particular, the current RCGP Chair of Council, Helen Stokes-Lampard, is indefatigable and impressively media savvy in raising public awareness of the threats we face. We too should take every opportunity we can create to challenge, courteously but without compromise, the 'don't worry, all is well' bromides regularly dispensed by government.

A SUGGESTION

Let's be charitable, and put our current resource famine down to a lack of understanding on the part of our masters, rather than incompetence or malice. To paraphrase Buffett, general practice is at risk because they don't really understand what it is we do. How else can we help them 'get it'? Perhaps we could learn from Hirst and Lim, and hitch our anxieties to a medium of mass communication.

In 2016, GP Graham Easton published a book called *The Appointment*,[9] in which he 'thinks out loud on the page' through the course of a typical morning surgery, allowing the reader to eavesdrop on the range and depth of thought it takes to negotiate the consultation's complexities, nine-tenths of which, like the iceberg, lie unseen beneath the surface. I suggest — and it's a serious suggestion — that the Royal College of General Practitioners should send a copy of *The Appointment* to every MP, or at least to the Secretary of State and his ministerial team, and to the members of the Health and Social Care Select Committee. There's a chance that such an unexpected act of corporate safety netting could do more to help them 'get it' than the usual round of making the usual representations through the usual channels.

Roger Neighbour,
Retired GP and Past President, Royal College of General Practitioners.

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ADDRESS FOR CORRESPONDENCE
Roger Neighbour
Email: rogerneighbour@gmail.com

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