Accessibility and availability: How can we cope?

IT is easy to forget that most people dislike being ill. Usually they don't want to see doctors unless it is really necessary. Then our accessibility is very important to them and is a criterion on which we are often judged, regardless of the facilities we are offering.

Since the 1960s, there has been a trend towards larger practices, which have been thought to make more business sense. However, this has led to a tendency for larger practices to provide less personal care (losing patients in the 'collusion of anonymity'), while doctors have tended increasingly to take on other commitments, such as teaching and clinical assistant posts. A recent study[1] has shown that patients prefer smaller, non-training practices and personal lists. A study of the movement of patients between practices (other than for changes of address) indicated a tendency to choose smaller practices.[2] In this month's *Journal,* Campbell[3] shows that larger practices, regardless of the number of doctors, are considered less accessible for appointments. It seems that small is indeed beautiful! As the author points out, we must distinguish between availability (provision of a service) and accessibility (how easy it is to use that service). What patients want most is to see a doctor as soon as possible.[4]

General practitioners have to live with the continued pressure of providing a service, with limited resources, to people who seem to make unlimited demands. In the absence of a public debate on rationing, it has been left to us to be the gatekeepers. Our workload has increased since 1990.[5] Large numbers of general practitioners feel overwhelmed, and develop a sense of loss of control and lowered self-esteem, which leads to depression and all its consequences.[6] We can turn from patient's advocate to adversary!

What can we do to reduce the pressure on us? Some of us can escape altogether by retirement or career change. The rest of us can either change the system or develop strategies to cope.

Let us look at the structure in which we work. I believe that the root source of many of our pressures is in the system of patient registration in the UK. We are contracted to be responsible for the health care of patients registered with us for 24 hours a day. Of course, this can lead to great benefits in continuity of care, relationship building and understanding of family dynamics, along with an ability to use populations for screening procedures. As we are paid mainly by capitation fees, there is an underlying philosophy that, if we keep our patients well, we can look after more of them and therefore earn more money. But the continuing responsibility and the pressures of perceived demands can grind us down.

Consider the consequences of abandoning patient registration. General practice would then have to be privatized. We have an example of one such system in urban Australia, where 'traditional' practices still work during the day. However, patients can choose any doctor in any practice. Alternatively, and for out-of-hours services, they can attend a primary care centre, which is staffed by doctors and nurses working shifts, covering 24 hours a day. Thus, the problem of out-of-hours demands is solved. Access to a doctor is almost always good and doctors are not subjected to long periods on duty. However, there is a catch: consultation rates are almost double those in the UK. This is largely because of patient demand, but it could also be because doctors are tempted to recall people more often in order to generate more consultations and a higher income. Of course, the people have to pay in the end, through a combination of national and private insurance schemes.

If we do not want to go down that road, let us consider retaining our registration system. How can we keep our sanity and yet provide relevant high-quality accessible health care to people whose expectations are being continually raised? Here are a few practical suggestions.

We could look at our own workload realistically and see if we could make better use of our time. Time management courses can be useful! If we build in enough appointments each day to deal with 'urgent' cases, and decisions about these are made with well-trained staff, backed up by consistent medical advice, then we can feel less pressurized by urgent demands. If we review people with chronic disease less frequently and agree on appropriate intervals, we could free more appointments. This would also abolish what is commonly called 'senior partner syndrome', where one doctor is always booked up far in advance, leaving the others in the partnership to deal with the more acute work.

We could delegate more of our work to nurses and other professionals, allowing us to look after our registered list of patients more easily.[7] We could divide large practices into smaller units or introduce personal lists. We could refuse to take on any more 'off-loaded' work from hospitals. We can learn from the supermarkets that there is no point in opening for longer hours as the total workload is merely spread out. 'On-call' stress has been reduced by the encouragement of more co-operatives in the UK over the past few months. We must ensure that we have protected leisure time. We could consider abandoning work from outside the practice. Would the resulting drop in income be a price worth paying to preserve our mental health? Is fund-holding really worth all the extra work it brings?

By taking some or all of these measures, it is possible to provide good accessibility for our patients. We will also take back some feeling of control, and the present rather depressed face of general practice could lift as we begin to enjoy our work once more.

PETER J M DAVIS

General practitioner, Leamington Spa

References

1. Baker R, Streatfield J. What type of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction. *Br J Gen Pract* 1995; **45:** 654–659.
2. Thomas K, Nicholl J, Coleman P. Assessing the outcome of making it easier for patients to change general practitioner: practice characteristics associated with patient movements. *Br J Gen Pract* 1995; **45:** 581–586.
3. Campbell JL. The reported availability of general practitioners and the influence of practice list size. *Br J Gen Pract* 1996; **46:** 465–468.
4. Consumers Association. Getting to see your GP. *Which?* March 1993,11–14.
5. Chambers R, Belcher J. Work patterns of general practitioners before and after the introduction of the 1990 contract. *Br J Gen Pract* 1993; **43:** 410–412.
6. British Medical Assocation. Doctors under stress. *BMA News Review* 10 April 1996, 32–34.
7. Marsh G. Caring for larger lists. *BMJ* 1991; **303:** 1312–1316.

Address for correspondence
Dr P J M Davis, South Farm Surgery, 110 Coppice Road, Whitnash, Leamington Spa, Warwickshire CV31 2LT.