

‘Access’— who needs it?

I have recently received a personalised letter of congratulation (the same letter went to all local GPs) from the chief executive of our primary care trust (PCT). I am supposed to share in the general exultation in the PCT that both ‘primary care access targets’ (proportion of patients able to see a GP within 48 hours and a primary care professional within 24 hours) have been met for the first time. The tone of such letters — both condescending and subtly intimidating — is objectionable enough, even though it has become increasingly familiar. But I take no pleasure whatever in the achievement of these targets, which symbolise the arbitrary and destructive character of government interference in medical practice.

The origins of the obsession with access, which has gathered momentum since Tony Blair’s election victory in 1997, lie in New Labour’s reliance on focus groups, the source of much recent government policy. Focus groups tend to exclude babies, children and the frail elderly, the chronically sick, the mentally ill and mentally handicapped, and all those, such as recent immigrants, refugees and asylum seekers, who do not speak English. In other words, such methods of public consultation exclude most of our regular patients. However, they include young adults, particularly middle-class men, a key electoral constituency for New Labour and a section of society that has become, in recent years, a rapidly growing source of demand for appointments at our surgeries. Such men are often brought — or sent — in by their partners, even by their mothers, or come on their own in the grip of anxieties about diverse health risks, seeking screening tests, investigations and reassurance.

The elevation of the demand for rapid access to doctors to the apogee of government health policy reflects the ascendancy of the preoccupations of the ‘worried well’ over the concerns of the chronically ill. Although young men with atypical chest pain or those who have suddenly discovered a miniscule epididymal cyst or a benign naevus on their backs believe they need an urgent medical consultation, in fact they would benefit greatly from a 2-week wait for an appointment (during which, in the vast majority of cases, their symptoms would disappear). But, while loud-mouthed yuppies barge to the front of the queue demanding immediate attention, backed by the full authority of the prime minister, the minister of health and the chief executives of the PCTs, the infirm and the elderly, and all the rest, who value continuity of care with the same doctor or nurse more than rapidity of access, lose out.

The priority given to access helps to explain why most patients have failed to experience much benefit from the substantial increase in government expenditure on health care. Although vast resources have been allocated to appointing ‘access facilitators’ and to the promotion of Advanced Access schemes, the result has simply been to encourage more of the worried well to demand more rapid access. Now that we have (apparently) achieved our target of 100% access to a GP within 48 hours, it remains to be seen whether even more heroic efforts can raise this rate still further and meet the demands of those particularly needy patients who want an appointment yesterday.

The promotion of rapid access with financial incentives has, like all such initiatives, encouraged all sorts of scams through which GPs can secure their income without too much disruption to their practices. Yet appointment systems that have evolved organically over time to suit the highly particular requirements of different practices have had to give way to systems dictated by the bureaucracy promoting the new orthodoxy (which, of course, continues to proclaim its commitment to local autonomy). One result of this policy is that it tends to give priority to those patients whose clinical need is lowest. Another is that it tends to provide a poorer service to those whose need is greatest.

Perhaps the most disturbing consequence of the great leap forward to meet access targets is that the pervasive cynicism that dominates government policy now extends its corrosive influence into every surgery in the country. In the telling phrase used by the last audit inspector of the practice of the late Harold Shipman, our chief executive signs off urging me to ‘keep up the good work’. Indeed the struggle to maintain standards of medical practice in face of bureaucratic intrusions driven by the imperatives of political expediency was never so difficult.

Opening the Hoard, my literature and medicine section in the journal *Medical Humanities*. If you don’t know it then subscribe now.) Ruth Richardson paints a graphic picture of what hospitals used to be like in the bad old days in her historical chapter.

The Healing Environment: without and within culminates in a superb chapter by Roger Higgs (a professor of general practice and a medical ethicist). An autobiographical reflection on medicine and general practice, beginning with a memory of tonsillectomy in 1949, he calls it a ‘brief and personal study of the change of the emotional and moral landscape’ of health care and medicine. I recommend this book for this chapter, and to appreciate the illustrations throughout. I hope you’ll read the other chapters too; your practice will benefit.

Creative Writing in Health and Social Care is full of experience of working with patients with dementia, hospital, hospice and occupational therapy patients, and those in primary care. This is innovative work — deeply helpful to the patients, illuminatively described. It also includes an excellent chapter by Robin Downie, a professor of moral philosophy. Robin writes very persuasively, pragmatically and unemotionally about medical humanities in medical education.

I’ve run out of space, and I’ve run out of time. You’ll have to read the books for yourself. Please do.

Gillie Bolton