Up close and personal?
Continuing pressure on the doctor–patient relationship in the QOF era

Three papers in this month’s Journal help us understand more about relationship continuity in today’s practice. Buszewicz et al selected 20 patients from 173 video-recorded consultations because their problems were particularly high in psychological content. They were interviewed about their experience to find out what aspects of the encounter were particularly helpful (or not). The authors conclude that ‘the doctor–patient relationship was central to all patients’ experience ... genuine interest and empathy, within a continuing relationship, was highly valued.’ These interviews suggest how the relationship actually works in a consultation and tell us how much it is worth our while to take the trouble to allocate time, skill and emotional effort, as well as the teamwork involved in allowing this to happen. The working of a therapeutic relationship with a known and trusted doctor is explored further in a recent Scandinavian paper. They specify a sense of security, based on four key aspects: feelings of coherence, confidence in care, a trusting relationship and accessibility.

In another cross-sectional qualitative study, using patient focus groups, Alazri et al show us how patients with diabetes value good relationships particularly with primary care doctors and nurses, but also with diabetic specialists. They remind us of a downside of ongoing relationships (‘familiarity breeds contempt?’) — that the usual practitioner may sometimes be too slow to notice change and make a new diagnosis of diabetes. This important issue has been reported before (as they quote) but it is hard to quantify and it may be indicative of patients continuing to see a doctor that they do not necessarily ‘know and trust’. Nowadays patients have the opposite problem — in large practices with many practitioners, often part-time, it is difficult for them to see the same person when they want to and there may be ‘collision of anonymity’ where no doctor is willing to fully engage with the patient’s problems. Yet this should make our task, and theirs, easier; it is more natural for a useful relationship to evolve over several consultations. We are always under time pressure, but Pereira Gray pointed out that a mean of five consultations in a year allocates the average patient a total of over 45 minutes. If most of these 45 minutes are with the same person this may allow a different and more satisfactory power balance to emerge. Guthrie and Wyke interviewed 32 patients in Scotland and report how patients had greater involvement in consultations with ‘their’ trusted doctor, particularly for chronic, complex and emotional problems.

Evidence that patients value relationship continuity is steadily accumulating. A longitudinal study of diabetic patients in general practice has recently produced its draft report. This shows definite association of patient satisfaction and wellbeing with better continuity — using a multi-aspect measure, including the relationship — but no definite association with better measures of disease progress over the admittedly short 1-year follow up period.

One of the factors encouraging patients to seek out the same doctor next time will be that doctor’s own behaviour. This will usually reflect the doctor’s priority for following up that patient personally. The paper by Schers et al suggests that doctors’ rationale for such behaviour may not be straightforward. Doctors’ attitudes to personal follow up in a postal survey were hardly at all associated with their wishes recorded immediately after each of a series of actual consultations. This is intriguing. The authors suggest some reasons why both of these methods may encourage responses thought to be desirable, such as specifically wanting to follow up sicker people. In real life I suspect we may be more idiosyncratic — perhaps giving warmer follow-up invitations to those patients we like best.

Professionally each of our patients deserves our consideration equally, but to deny the personal nature of our exchanges with patients denies a key aspect of our discipline and also the intensely personal nature of illness and suffering. It favours the technical fix over the effort needed to understand people’s problems and so help them cope. Thus, the warmth of our relationships is likely to influence how we invite patients to consult us again. The challenge is to identify these feelings and to compensate for them in behaving according to the clinical need of the individual who seeks our help.

The June issue of this Journal had a distinctly pessimistic air. Elwyn voiced doubts about our ability and motivation to be patient centred or share decision making in practice (‘idealistic constructions built by academic thinkers?’) while McGregor and Campbell reported that consultation rates for depression and anxiety have fallen since the start of the Quality and Outcomes Framework (QOF). But the QOF can be robustly defended. It is a brave attempt to spread good preventive medicine across the board to all communities, as famously advocated years ago by Tudor Hart. We cannot see any measurable benefits yet — it may take at least a decade and we should remind our critics of this.

Meanwhile QOF is like a large cuckoo in our nest. It is certainly time and resource consuming and must tend to squeeze out the care of individuals whose needs don’t ‘fit the boxes’. The risk of the measurable crowding out the valuable is real and the subject of much anecdote, such as the recent ‘personal view’ beautifully expressed by Diana Jelley.
She describes the personal care of an elderly woman with multiple pathologies and her eventual death after a relationship of 14 years, including many home visits.2 Keeping her notes on computer involved repeated suppression of automatic warnings as disease-orientated norms were necessarily compromised.

Of course the human side of practice is very much alive. Join any group of GPs in these days of QOF and you will still hear a fund of stories about individual patients and their curiosities. This is one of the most rewarding parts of our work. Yet seeing a succession of people over long consulting hours and being fresh for each individual remains very taxing, and ticking the QOF boxes makes this even more so.

The expert patient may be perceived as another potential challenge to our ability to keep time and get through the day. As Elwyn reminds us, we are tempted to direct our well-honed communication skills in an authoritarian way to ‘gather the low hanging fruit’ and end the consultation as soon as we can.8 One problem of the increasing number of ‘control visits’ for aspects of ongoing care under QOF is the opportunity for patients to raise other issues that may never have motivated them to seek a new consultation. These wants sometimes feel limitless and cost time. When patients were encouraged to list all their wants on paper before their consultation in a recent study, the result was indeed longer consultations — by up to 27%.13

So, in spite of any temporarily increased pecuniary wealth,14 QOF is associated with unremitting pressure on scarce consulting time. Evidence that relationship continuity (encouraging and allowing patients to consult with their chosen professional to develop a therapeutic relationship) leads directly to better health outcome measures remains elusive. But evidence that both patients and professionals feel better with relationship continuity continues to grow. It is at last recognised specifically in the recent White Paper,15 although we need to think much more carefully about whether our patients would best be helped by incentivising financially what we should better do for our professional satisfaction.

Just how hard some patients have to work to get to see their chosen clinician is shown in another recent longitudinal study.38 So, right now we should be training our teams (receptionists as well as clinicians) to specifically encourage relationship continuity whenever possible. This will help us all cope with the pressure and even enjoy it!

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Polypharmacy, appropriate and inappropriate

I have seen it asserted that ‘polydactyly’ is an inappropriate word, because it means many digits (fingers or toes), and we all have many digits. This analysis is superficial. The Greek word πολυς (polus) had several meanings, such as many, mighty, long, and wide. The English prefix poly- usually takes the first of these meanings; polymyalgia means pain in...