Out of Hours

Reflections on a research study about refugees and asylum seekers

How many papers presented at conferences reach publication? How many small studies completed for higher degrees never reach peer reviewed literature? Do they have important messages we can use in our professional lives?

I often reflect on these questions while commuting to and from work and considering how to disseminate the small-scale studies I am involved in as a medical educator.

A senior professorial colleague brought these ruminations into sharp focus recently. The conversation went roughly as follows. 'Did you present a paper at SAPC a long time ago about refugees?' 'Yes,' I replied, 'A decade ago … it was my masters … I never got round to publishing it'. 'Well …' he said, 'it changed my practice'. And then went on to clearly identify the key points of my masters dissertation and how he currently used them in consultations.

This stopped me in my tracks. I was stunned. I had done something that had influenced someone who I didn’t know at that time. He had listened to my 10-minute short oral presentation at the Society for Academic Primary Care and turned the results into actions within his practice that still had relevance 10 years down the line.

I am a GP and run an undergraduate clinical skills programme, so aim to influence behaviours in my daily life, but the concept of a piece of research completed a long time ago currently influencing a senior colleague was a different matter. Publication at that time for me was the territory of the professional researcher; not a fledgling GP considering how to progress their career while juggling life. Other things got in the way and I never published the study.

BRIEF SUMMARY OF THE STUDY

Background

In 2002 as part of my masters in primary care dissertation, I completed a study about access to primary care for refugees and asylum seekers. The aim was to identify how the initial point of contact could be improved in the health economy I was working in at the time; Barking and Dagenham in Essex. I received a small grant from the Claire Wand Fund¹ and ethical approval from the local research ethics committee.

METHOD

I convened three focus groups with refugees and asylum seekers in their own languages using interpreters, translated the data into English using the same interpreters, and analysed the results using the Framework technique.² I then completed 15 interviews with local GPs and practice staff. Again this was analysed using the Framework technique.

RESULTS AND DISCUSSION

The participants included Albanian-speaking and African French-speaking refugees and asylum seekers, from established communities in Barking and Dagenham.

The main themes that emerged were about the divergent perspectives of the health professionals and those groups of refugees and asylum seekers and how these differences led to frustration and conflict in consultations. One of the key themes identified was that these individuals were used to managing risk in their lives. This involved attempting to exert control over their interactions with the agents of health care to try to manage these interactions in the way they would have done, prior to coming to the UK.

Their previous experiences often involved purchasing health care and so the UK health system, where care is free at the point of delivery, presented them with challenges that the healthcare teams did not understand. The refugees and asylum seekers perceived stigma and risk in some primary care consultations where no referral to secondary care was made or no prescription issued. This lack of action was viewed as a reflection of their status rather than management in the patient’s interest and confrontation often followed. When these views were explored and reassurance offered, the tensions frequently resolved. This highlighted the role of communication skills in exploring others’ perspectives and negotiating a solution.

How much other untapped work is available that we cannot access via an internet search? How many small nuggets of work completed for personal development have the power to influence others and benefit patient interactions?

I do not presume to offer an answer but hopefully to inspire individuals who have completed or are completing a masters, to consider disseminating their research so that all those hours of work have the possibility of impacting on someone beyond themselves.

REFLECTION FROM THE ‘SENIOR’ COLLEAGUE

The results of this study represented a personal ‘eureka’ moment. Suddenly it was obvious why so many consultations with new arrivals were so confrontational: in their eyes, I was denying them the care, which everyone else received. For me, the paper had a deep and suddenly obvious truth. The changes in my practice were simple:

• explain to those whose previous health care experience had been outside the UK that there are many conditions for which the appropriate and evidence-based care is watchful waiting;
• that is why I am suggesting ‘do nothing’; and most importantly
• this would be the case for everyone.

Consultations with new arrivals did not become easy but certainly became easier. I have always felt that we have insufficient feedback from peers, seniors, and juniors. It took me a while to work out that my new colleague was indeed the author of the neat little paper I had heard many years ago which had caused me to reflect on the challenges of working in a multicultural practice with many new arrivals. Having worked this out, I thought it appropriate to tell her; after all, I am pleased when someone says that they know of and use my work.

I am somewhat surprised and gratified...
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Viewpoint

The three ‘T’s

I am a junior doctor, training to be a GP, and have a 6-month posting in A&E next year. I’ve been reading with avid interest about the need for patient education, more robust GP out-of-hours services and an increase in GP appointments, but feel we need to fundamentally improve how doctors and patients experience A&E. Although there are many complex issues, three ‘T’s are the most important.

TIRING ROTAS

My main concern about A&E is that it does not promote patient safety. My A&E rota has stints of 10 days in a row on 10-hour shifts. After 1 day off I then work three 10-hour night shifts. This equates to 130 hours in 14 days. This is normal for many A&E doctors. As a patient, would you want to be seen by a doctor on that 14th morning? As it is, this is a highly pressured, difficult, and traumatic job involving making important medical decisions fast. Yet A&E rotas include even longer stretches of physically and mentally demanding shifts that are normally recommended. On top of this, antisocial hours and frequent weekend working further removes the support of seeing family and friends.

TRAINING

Who would want to work and train in these conditions? A career in A&E is not a popular choice for medical students. I chose A&E to become competent in many areas, among them ophthalmology, orthopaedics, and paediatrics. Many registrars (supervisors) are not in A&E training posts because they do not want to commit to a career in emergency medicine, so there may not be the guidance, leadership, and support required to nurture learning and development for junior doctors.

TARGETS

The atmosphere in A&E is one of constant tension. The nurses have to pressure doctors to make decisions, and we struggle with the medical team to get patients admitted. Although everyone tries to focus on patient safety, and most days healthcare professionals respect and treat each other well, the ‘target culture’ (such as the 4-hour wait target) often creates a strained and difficult atmosphere full of blame and mistrust, centred around targets not patients.

The three ‘T’s aside, A&E is a fantastic learning opportunity in acute medicine. But the current culture needs to change. Many doctors [including myself] see their time in A&E as ‘earning their stripes’ but this is not safe. So what is the solution?

Doctors working stressful 10-hour shifts should not work more than 4–5 days straight, so that they have time to recuperate and sleep. Sleep deprivation has been shown to be equivalent to alcohol consumption in its effect on decision-making. Having some annual leave that is not fixed would also lead to happier doctors who have more social support.

A&E needs to be a safer and more appealing place to work. Although time targets are important, reviewing them and introducing new targets, especially around preventing re-admission, would create a more patient-centred service.

There should be clear and transparent guidance on admission for GPs and A&E staff. Education could focus on learning about patient outcomes and effective referral pathways. Better communication and feedback between hospital doctors, GPs, and A&E staff should be encouraged, with shared learning opportunities to promote unity.

Ultimately, more trainees will be attracted to A&E if there is an engaging atmosphere that nurtures and improves their diagnostic skills while respecting their need for training and social support. This will require funding, but in the long term it will defuse the ticking time-bomb of direct and indirect costs due to over-worked, over-tired, and potentially under-performing doctors. And, next time you are in A&E you won’t have to worry how many days your doctor has worked without a break.

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REFERENCE