Discretion is the better part of general practice

I shadowed a GP working in one of Glasgow's most deprived areas. She arrived at 7.20 am on a Monday morning to deal with 38 items of correspondence, all needing to be checked and prescriptions altered, a patient phoned, or arrangements made, before the day even started. The telephone calls to patients all began the same way: 'This is Dr xxxxx, Hello John, Hello Helen etc'.

As the on-call doctor on a busier day than usual, she completed seven house visits that morning, each taking 30 minutes. It took an hour to enter all the details back in the practice and make the necessary arrangements, leaving 5 minutes for lunch. A colleague who took over the on-call for the afternoon made three more home visits, dealt with 22 telephone consultations and six emergency appointments.

The afternoon surgery ran for 3 hours, and would have lasted longer if all the booked patients had attended. Problems addressed included: cancer, depression, agoraphobia, asthma, self-harm, bereavement, domestic violence, heart failure, alcohol abuse, dementia, social neglect, and so on, often in combination. She left for home after a 12-hour day, with 61 items of correspondence yet to deal with.

I didn't see any short or trivial consultations. There were no 'worried well' patients, but a worried doctor leaving no loose ends when dealing with a series of patients with complicated health issues and other problems, all of whom she knew well. One patient said 'Dr xxxxx" is the only person I can relate to'. Another came in grim-faced, avoiding eye contact, almost in tears, but left 15 minutes later, beaming a smile.

I was struck by the intensity of the day, every patient getting the same attention. The doctor was too busy to put on an act: 'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'. The practice has learned from experience that it is unsafe to assume that if problems are serious, patients will consult in time.

There are three GP partners and none work full-time: 'You cannot work fully concentrated for a whole day without recovery time'. The practice is wondering whether it might attract more students to their list to dilute the clinical load. Burn-out is an ever-present hazard. The level of work is hard to sustain.

"'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'."

The consultations I observed showed a GP at the top of her game. Previous contact, shared knowledge, and trust were fundamental to what could be achieved in a short space of time. Despite the pressures of practice in a deprived area,[1] the GP was ambitious for what she could achieve with, and for, her patients.

One seldom gets the opportunity to observe a GP through a whole working day. What I saw in Glasgow reminded me of working with Julian Tudor Hart at Glyncorrwg in South Wales. He is best known for research on high blood pressure, but his daily practice and long-term achievements were characterised by his unconditional approach to all patients, whom he came to know well, whatever problems or combinations of problems they had. In the BBC documentary series on the NHS *Pioneers*, Mary Hart said 'Many people sentimentalise us, but we were just doing our job, for which we were paid, providing the NHS for our patients.'[2]

In an article with Paul Dieppe, Tudor Hart described the poisonous effects which can arise when, for whatever reason, health professionals become indifferent to what happens to the patient in front of them.[3] I remember him talking of the importance of finding something to like about every patient. There was no-one about whom there wasn't something to like.

In the 1950s, Collings described poorly-resourced areas of general practice as 'sufficient to turn a good doctor into a bad doctor in a short period of time.'[4] Such gross effects are less common today. A more subtle effect is whether practitioners set the bar high or low when dealing with patients.

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The incentives of the Quality and Outcomes Framework, involving only 12.7% of GP consultations,[5] have little to do with this aspect of practice. Professionalism and caring for patients are what matter, and both are at the discretion of individual practitioners.

Consultation rates are used as crude measures of practice activity and proxy indicators of health need. Such data convey nothing of the duration, content, quality, or consequences of consultations, and their use sustains the inverse care law.[6] What I saw in 1 day in one practice in one part of the country goes unrecorded in the scheme of things, reflects poorly on the NHS commitment to equitable resource distribution, but spoke volumes for the professionalism of one GP.

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