

Editor's choice

I want to be a GP, but the government is doing everything it can to stop me. Mr Hunt's brilliant answer to the crisis in GP recruitment is to slash trainee pay by 30%, penalise doctors taking maternity leave or extra degrees, and extend normal working hours.¹ Morale among my peers about to apply for specialty training is catastrophically low. As a result, the majority of my friends are looking to move from the NHS and take a 'Foundation Year 3: FY 3' because they perceive that their immediate future here is bleak. At a time in our careers when we should be optimistic and enthusiastic, it's tragic that the state of the English NHS is leaving us so disillusioned. Scotland has dismissed the new junior contract, making a move north ever more tempting. We need a strong positive message from senior doctors that there is a bright future in English general practice, and a commitment from government that our incomes will be protected and our efforts valued.

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Is general practice engaged with physical activity promotion?

A further dimension to GPs' limited knowledge of the Chief Medical Officer's advice on physical activity described by Savill and colleagues¹ lies in the health of primary care physicians themselves.

As a sedentary profession with long office hours, this finding indicates that GPs may be

at increased risk of the very same physical and psychological consequences they seek to prevent in their patients. Such a conclusion could have wider implications for the public because patients' perceptions of GP health are reported to influence their facilitation of advice given.² This effect is not simply based on physical appearance of health and weight; one of the key determinants is the disclosure of the GP's own health behaviours.² While growing attention has been paid to burnout in GPs,^{3,4} the impact of working conditions on the physical health of GPs needs to be considered further. Opportunities should be created within annual appraisals to promote greater discussion of this, in particular strategies to address physical inactivity.

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The 10-minute appointment

In an RCGP news item¹ issued to coincide with the publication of the discussion paper

Patient safety implications of general practice workload,² reference is made to the 'constraints of the standard 10-minute GP-patient consultation'. The paper itself discusses the safety implications of fatigue, and states that individuals are more likely to make mistakes when 'late', but there is no mention of the role of the 10-minute appointment.

It is implausible that extra funding or staffing in primary care would reduce the number or complexity of the problems which patients wish to discuss in an appointment, so should we reconsider the use of the 10-minute appointment?

Why have 10-minute appointments become a problem? Some of the causes are beyond our control: an ageing population with multiple comorbidities, a shift of care from secondary to primary care, and increased patient expectations. Others are a direct result of changes we have made: by delegating routine reviews, minor illnesses, and other straightforward cases to other healthcare professionals. And by using 5-minute telephone consultations instead of face-to-face reviews we have pruned the 'quick' consultations from our own surgeries and left our lists full of complex physical problems and time-consuming psychosocial issues. For medicolegal reasons we also spend longer documenting our consultations. Busy patients, not unreasonably, hope that we will deal with all their problems at one appointment, and when we 'run late' our waiting patients have time to convert their various ailments and concerns into a very concrete problem list.

When a patient's problem(s) are not able to be safely and effectively dealt with in a 10-minute appointment there are only three possible outcomes: the problems are not adequately dealt with, they are dealt with but take longer than 10 minutes, or the patient is asked to make a further appointment. All of these outcomes are bad for patients and stressful for doctors.

If we could improve both patient care and GP morale by increasing the length of our appointments, what have we to lose? If instead of having 18 10-minute appointments we have 18 12½-minute appointments our surgery would be 45 minutes longer, but that would be partly offset against the time we normally 'run late' and a reduction in repeat appointments. We might worry that 'quick' consultations or patient DNAs would cause

wasted GP time. In reality, there are jobs that we can do without leaving our desks that are quick and interruptible: post, pathology results, prescriptions.

Changing appointment length is simple to trial, and reversible. As GPs seeking 'the courage to change the things we can', should we now seek to improve patient care and reduce our own stress levels by consigning 10-minute appointments to the history books and declaring that they are no longer fit for purpose?

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Why do 'high risk' women book late or not at all for antenatal care?

The editorial on maternal health in pregnancy identifies issues relevant to primary care arising from the 2014 *Confidential Enquiry into Maternal Deaths and Morbidity*.² The authors recommend targeted pre-conception and antenatal interventions for women with long-term medical, mental health, and substance misuse conditions, especially for those with additional risk factors; for example, smoking and obesity, compounded by adverse socioeconomic characteristics. However, of the women who died, 61% failed to receive the recommended level of antenatal care and 10% received no antenatal care at all. The recommendations will be difficult to achieve in women who do not attend primary care appointments and/or present late or not at all for antenatal care, an issue acknowledged but not addressed within the editorial.

There is a dearth of research into why some women fail to access timely, freely

and locally available antenatal care in the UK and what impact this phenomenon may have within populations of pregnant women already known to be at higher risk of adverse materno-fetal outcomes. Stereotypical, professionally derived perspectives prevail: the 'concealed' pregnancy; ambivalence/lack of self-care; denial; therapeutic nihilism relating to socioeconomic and cultural factors. In our qualitative study, undertaken with a socioculturally and age-diverse group of women, we identified a novel taxonomy of reasons for late or non-booking for antenatal care. These included NHS system and professional failures that 'delayed' access to timely care and maternal factors: 'not knowing'; 'knowing' with postponement and perceived optimisation of self-care.³ A lack of reproductive health knowledge was a cross-cutting theme, which compounded other barriers to timely access to care; our sample included women who had presented late or not at all for antenatal care in previous pregnancies. Policy-makers should 'join up' and optimise all facets of maternal health care within public, primary, and secondary healthcare settings and improve reproductive health knowledge for all women, including opportunistic interventions. The 'take-home messages' within this editorial may only partially address yet another NHS health inequality conundrum. Taking maternity care to hard-to-reach women is an idea whose time has come.

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Patient consent and opting-out

Consent issues reported as 'unsatisfactory in this journal in 2008'¹ have again stalled the national programme for storage of patient information. Many patients were unaware that they had agreed consent for personal medical data transfer to the Scottish Emergency Care Summary following a mailshot.² Failure to question the effectiveness of a mailshot opt-out system has now cost NHS England dearly. Mailshot opt-out compromised the advice of the MDU, the RCGP, and the GMC. According to the Health and Social Care Information Centre up to 700 000 patients have requested an opt-out from care.data, consistent with our practice 16.5% opt-out.

The opt-in option should be considered. Opt-out, particularly by mailshot, diminishes the likelihood of informed consent. Opt-in balances risks and benefits personal need to share data but reduces value to commerce or science. GPs' data serve individuals, not commerce. The GMC states, 'Make the care of your patient your first concern' and emphasises 'express' consent before disclosure. The opt-in arrangements lie more comfortably with this guidance. Ironically, the data managers failed to understand and assimilate published data. With the certainty of hindsight further incontrovertible evidence reveals opt-out is flawed.

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