Saul Miller

Part-time relationships

We knew each other already: we both used first names comfortably. Stoic as she might be, she was ill and I was seeing her at home, in her lounge. I had just finished examining her on the sofa and, having sat up again, she was leaning back concentrating on her pain. I was on an adjacent chair, and having arranged the admission was now writing a letter to go with her. My legs were crossed and my shoelace loose. The pain easing for a moment, she noticed this detail and reflexly leant forward to correct it.

I looked up sharply from my letter but she simply smiled. *'I am a granny you know,'* she reassured me. I laughed, she completed the act, I finished the letter and left.

What was so surprising about it, I wondered afterwards? There was no surprise that I moved to examine her and she complied. There was no surprise that I should demonstrate caring either. It was the reciprocation and more particularly the physical contact involved in that.

Is 'patient touches doctor' in the same ball-park as 'man bites dog'? Stuff like this happens with time though.

Most people want a relationship with their GP, particularly if they think their problem has significance.[1] The very nature of a relationship is that it involves some element of reciprocity. Not necessarily much: even tying my lace was unusually demonstrative. But it has to be there, somewhere.

A relationship can only exist if there is continuity however, or at least the expectation of some. Without that, consultations tend towards being merely transactional.

Using continuity as a proxy measure for patients having ongoing relationships with their GPs, there is plenty of evidence for the benefits. Notwithstanding my patient, it is associated with reduced rates of hospital admission.[2] It is even associated with better survival among older patients.[3] It is no surprise then, that family doctors value such relationship continuity.[4] It is not just about the patient either: it also benefits us.[5]

Yet perversely, declining continuity is part of the current crisis in family medicine.[6] This crisis of rising demand and falling resource, including one of frighteningly waning manpower,[7] is taking an increasing toll on those who are still manning the service.[8]

An obvious way to respond to excessive pressure is to reduce exposure. We recommend strategies like this to our patients all the time.

I have done this, working only 3 days in practice mostly. In fact I also teach for the local GP training programme and it is now a rare event for trainees to wish to work more than part time when they qualify. Of course, trainees' hours are so carefully controlled and limited that this is itself bound to affect their future expectations.

Let's face it: the 4 hours and 10 minutes definition of a GP session[9] was only ever nominal. No nine session full-time GP has ever worked anything remotely as little as the mathematically implied 37.5-hour week.

There are a great many 'part-time' GPs who are working more than 37.5 hours each week. As has been pointed out, that terminology is itself a part of our problem.[10] Nevertheless, the impact of most of us trying to limit our exposure is to help feed the vicious cycle of rising work pressure and declining continuity.

We all have our limit of what we can give and relationships are key to maximising that. Our patients know this even if their government does not.

Even tying a lace helps.

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REFERENCES

1. Schers H, Webster S, van den Hoogen H, *et al.* Continuity of care in general practice: a survey of patients' views. *Br J Gen Pract* 2002; **52(479):** 459-462.
2. Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. *BMJ* 2017; **356:** j84.
3. Maarsingh OR, Henry Y, van de Ven PM, Deeg DJ. Continuity of care in primary care and association with survival in older people: a 17-year prospective cohort study. *Br J Gen Pract* 2016; DOI: http://doi.org/10.3399/bjgp16X686101.
4. Stokes T, Tarrant C, Mainous AG 3rd, *et al.* Continuity of care: is the personal doctor still important? A survey of general practitioners and family physicians in England and Wales, the United States, and the Netherlands. *Ann Fam Med* 2005; **3(4):** 353-359.
5. Eby D. Empathy in general practice: its meaning for patients and doctors. *Br J Gen Pract* 2018; DOI: http://doi.org/10.3399/bjgp18X698453.
6. Levene LS, Baker R, Walker N, *et al.* Predicting declines in perceived relationship continuity using practice deprivation scores: a longitudinal study in primary care. *Br J Gen Pract* 2018; DOI: http://doi.org/10.3399/bjgp18X696209.
7. Rimmer A. Full time GPs fall by over 500 in three months. *BMJ* 2018; **362:** k3652.
8. Rimmer Abi. Two in five GPs have had mental health problems, survey finds. *BMJ* 2018; **362;** k3638.
9. British Medical Association. Job planning guidance for GPs. 2018. https://www.bma.org.uk/advice/employment/job-planning/job-planning-guidance-for-gps (accessed 4 Sep 2018).
10. Morris I. We need to stop talking about GPs being "full time" or "part time". *BMJ Blogs* 2018; **20 Aug:** https://blogs.bmj.com/bmj/2018/08/20/ian-morris-we-need-to-stop-talking-about-gps-being-full-time-or-part-time (accessed 4 Sep 2018).