"... it is hard to persuade a young doctor to commit to a lifetime in a small practice with limited professional contact, no career progression, financial risk, and open-ended responsibility."

Paperwork

Small practices are the best, with good continuity and knowledge of the patients. But the reality is that small practices are failing. For it is hard to persuade a young doctor to commit to a lifetime in a small practice with limited professional contact, no career progression, financial risk, and open-ended responsibility. This at a time when GPs are pulled in every direction. Consulting, house calls, callbacks, prescriptions, reports, and 'paperwork'. Work is out of control, many GPs are miserable, *'It's just not the job I signed up for ...'*. We are in a terminal spin of decline.

So although people like corner shops, we all use supermarkets. Supermarkets are convenient, offer choice, and guarantee a certain quality. Supermarkets are also well regulated, with guaranteed employment rights and good pay. Being bigger isn't better but it is today's reality. A key benefit of scale is productivity, not a concept considered much in medical school. Our working day can in fact be broken down into various work streams like consulting, house calls, callbacks, prescriptions, reports. It is much more productive having one clinician doing one activity at a time. Consider how this works for clinical email.

You have survived the day to discover 100 pieces of electronic mail in DOCMAN. You chose to either skim read these with the high chance of missing important information encrypted in the impenetrable pseudoscientific prose, or kick it down the road for another day, risking delays in treatment, or spend 2 hours trawling through this, adjusting medication and coding, and getting home at 8pm. None is satisfactory. All raise governance issues.

This can and should change. Practices can process mail centrally. Train admin staff to read all the mail add codes. Training done systematically to a protocol. Admin staff then send mail that needs action to one account (we call this the RAD 'Results And Document' account). Mail that needs no action or the irrelevant chaff from hospitals is passed to another account (we call it the '2eyeball' account). A simple binary system.

A clinician (this can be a doctor, advanced nurse practitioner, or pharmacist) then reviews the 'RAD account', checking coding and adjusting medications as needed, texting or calling patients. The other low-risk mail in the '2eyeball account' can be quickly screened by a senior admin (or clinical member of staff if you prefer) and sent to file.

Add in a third option if you like and send all hospital discharge summaries and medicine changes to a clinical pharmacist. This has evolved this further. We offer contracts for clinicians to work remotely from home, screening the RAD mail; this can be done flexibly in the morning, evening, or weekends as it suits the clinician. This provides continuity and consistency. Every single piece of mail is double checked (a '2eyeball' policy) and mail is turned around in 48 hours.

Good governance and good medicine, but, most importantly, no one is staying till 8pm.

Des Spence,
GP, Maryhill Health Centre, Glasgow.

DOI: https://doi.org/10.3399/bjgp19X701165