Tim Senior

"Our patients also get to try us out. I know I've had patients come in a few times to ask about their sore throat, banged toe, then cough, before telling me about their depression and suicidal ideation several consultations in. These only come out when we have handled unimportant stuff well enough to have developed their trust."

Exclusion criteria: none

Let's call her Sharon. She comes to our clinic several times each week, worried about her children's illnesses, and presents to the emergency department often. I am always tempted to be a bit dismissive, but the family do have some particular health problems too, and my intuition is waving a small red flag in my head. Most of the illnesses are relatively minor, though, and she would be flagged as a frequent attender, ripe for some preventive intervention, or self-management education, whose presentations would be labelled inappropriate.

Looking around at the health system, it feels like the gates are all built to keep people out. Everywhere we look, we see referral criteria, 'inappropriate attendances', and sometimes rudeness to patients, telling them where they should have gone. Encouragement of self-management can easily tip over into encouragement of 'manage without services'.

It's not that every health service should have an open-door policy — in effect that is impossible, and leads to an unwritten rule where the only criteria for access is ability to pay. But as health systems get squeezed for funding, and capacity becomes more limited, the ability to keep patients out becomes more important, whether this is through formal policy, or informally, through increasingly pressured interactions of staff with patients.

General practice is the only part of the health system where we will see anyone who thinks they need to be seen. It's not easy doing this. We all have our fair share of people who we find it difficult to see. Also there are many problems people present with that are beyond our influence to improve, because the biological causes have social and economic causes. However, we are often the only place people can go for affordable, independent advice on problems that are giving them symptoms, or who might advocate on their behalf.

Not only this, but a GP waiting room is a legitimate place to be. Our patients might be there for a sore throat, a bruised knee or 'a touch of flu'. If you're spotted waiting for an appointment in the sexual health clinic or to be seen in the psychiatry unit, there will be speculation about the precise diagnosis that brings you there.

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And so, knowing Sharon quite well, and after a long discussion about her child's symptoms this time, I acted on a hunch.

'Are you safe at home?'
'He's only laid a finger on me a few times,' she said. *'He does threaten me, and I tell him that I'll get my dad and brother on him if he does anything.'*

These consultations are long and draining but they are crucial, life-saving ones. They only come about because people can see us about anything, including 'trivial' things, and because we have the opportunity to develop trust over time.

This is swimming against the tide, though, in a system that wants to preserve its valuable appointments for the better off or easier to handle. We need to recognise this ourselves and persuade others of the need for it, as an issue of safety and effectiveness, not just in the abstract, but for patients like Sharon.

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