Are we seeing more complex patients and, if so, why?

You might be left scratching your head after a long clinic with consecutive, complex consultations, an occurrence that feels increasingly common to me. I wrote recently on *BJGP Life* about the domino effect of unintentional consequences from the Additional Roles Reimbursement Scheme (ARRS), a complex intervention within a complex system. In their report, *The Future of General Practice*, the House of Commons Health and Social Care Committee (HSCC) suggested that the introduction of these new professionals into practice has left GPs dealing with multiple challenging cases 'one after another', which they cite as a contribution to clinician burnout, decision fatigue, and increasingly detrimental effects on patient safety. But do the ARRS roles lead to GP clinics filled with increasing complexity, and what are the other contributory factors?

What makes a consultation complex?

Multimorbidity is common and is increasing, especially among an ageing demographic as in the UK. Recent projections suggest that, among people aged >65 years, more than 68% of the population will have more than two chronic medical conditions by 2035. GPs know that this ageing and increasingly multimorbid population is leading to increasingly complex work, usually without additional resources. But it is not just multimorbidity and ageing at play here. The catalogue of factors contributing to increasing consultation complexity also includes increased management of chronic conditions in primary rather than secondary care, earlier discharge from hospital, increasing management of patients on long secondary care waiting lists, and increasing social care needs.

To answer what really makes a consultation complex, a research team used a Delphi consensus approach, then a cross-sectional study to develop and validate a measure of consultation complexity, which in its final iteration included factors such as multimorbidity, polypharmacy, mental health presentations, and doing more than two preventive or routine tasks in the consultation. However, the authors acknowledge that the concept of complexity is 'nebulous', and, while clinicians know what it means to them, it is hard to define, and may not be defined or measured in the same way by those thinking about it or experiencing it in a different way. It would, however, be interesting to use tools such as the one above on consultation complexity to examine trends in complexity by professional groups to examine the HSCC assertion that GPs are increasingly left dealing with the complex cases.

Losing the 'easy wins'

With patient, system, and social factors contributing, how might the increasing workforce mix in general practice impact on consultation complexity? Some GPs feel that ARRS team members peel off the 'easy wins', leaving them with the complex patients with multimorbidity who come to clinic with a list of issues to tackle within a 15-minute, or an even more challenging 10-minute consultation. A King's Fund report looking at the integration of ARRS roles into general practice mirrored this view, with one GP commenting that *'every time somebody takes an aspect of my work, they often take the work that is either simplest or fun and that leaves me with ever-more complex and exhausting things …'* Bethan Jones and colleagues very recently published a paper in the *BJGP* looking at the views of ARRS professionals on the implementation of the scheme in practice. While some practitioners, such as pharmacy technicians, felt that they were reducing the administrative load from GPs, many others on the ARRS scheme acknowledged that they were not reducing the clinical burden.

> "Could there be a role for adopting a practice policy of extended, person-centred consultations for particularly complex patients …"

Are ARRS team members ready to take on complexity? Some of those in ARRS roles, for instance, paramedics and some nurse practitioners, have more experience in acute care sectors. A recent workforce impact assessment of ARRS roles led by the Queen's Nursing Institute suggested that these members of the ARRS team may have limited experience in managing long-term conditions, which leaves other clinicians left to undertake more complex reviews. The report described this as 'taskification' where people with less experience in primary care delivered more fragmented, task-based care rather than a holistic patient-based care model.

Fragmentation of care

GPs can experience several challenges when working with patients with more complex needs, including dealing with this fragmented care in a time of decreasing relational continuity. Most clinical guidelines are written for single conditions that don't always consider multimorbidity and complexity, so GPs need to rely more heavily on their clinical judgement. Consecutive complex consultations can contribute to cognitive fatigue.

Here is where meaningful continuity really counts. GPs who don't know their patients feel they have to go back to 'square one' with complex patients, and that takes more time to try to get

right. And probably continuity is where the complexity peels away, because over time, as a doctor and patient begin to understand their relationship and what they bring to the table, many problems won't seem quite so complex after all. This rings true to the core of relational continuity as person-focused care over time, rather than a focus on just managing disease. With relational continuity, one practitioner with knowledge about the patient can help to develop a holistic view of the patient, their priorities, and how to manage complexity as a whole, and, dare I say, sometimes ends up leading to a rewarding encounter for the clinician and the patient. This is a far cry from the increasing 'taskification' of primary care, so thought needs to be given as to how to offer better relational continuity and management of complexity within the multidisciplinary team.

Final thoughts

We have just heard that the funding for the ARRS scheme is being continued, which provides us with an opportunity to think carefully and reflect on our experiences so far. Fragmentation of care is one area that is impacting on patient and practitioner experiences, and with increasing diversity in the multidisciplinary team, the evolution of the primary care micro-team needs further testing and evaluation. Could there be a role for adopting a practice policy of extended, person-centred consultations for particularly complex patients as suggested in a recent paper published in the *BJGP*? And as more evaluations of the scheme roll in and we learn from how workforce diversification impacts the multitude of complexities in general practice, we have an opportunity to think carefully how to rejig services accordingly.

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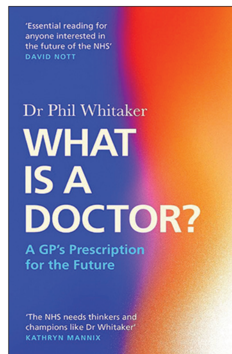
Books

What is a Doctor? A GP's Prescription for the Future
Phil Whitaker
Canongate Books, 2023, HB, 320pp, £14.39, 978-1838857974



Our dream

Whatever happened to our dream? This question, the central theme raised by Phil Whitaker's book, *What is a Doctor? A GP's Prescription for the Future*, must resonate with many GPs across the UK. It certainly did with me.

In factual terms, Whitaker's depiction of general practice narrates the practical implications of policy changes over the author's lifetime and the challenges these pose to the traditional values of general practice — alongside the impact on individuals, society, and the wider system. However, the book's value runs far deeper than this.

Through the stories of Marta, Matilde, Daniel, Charlie, and many others, we learn about the impacts of medicalising 'lifestyle' conditions; the Quality and Outcomes Framework and evidence-based medicine; the 2004 GP contract and loss of 24-hour relational-based care; the National Risk Service; 'Martini Medicine' ('anytime, anyplace, anywhere'); multimorbidity; overseas doctors; the workforce crises … and more. There are eloquent lessons for individuals, GPs (and their teams), and policymakers — if they are willing to listen.

More importantly we learn about the relationships GPs forge with their patients and the profound impact of this interpersonal knowledge and continuity — difficult to measure and thus often overlooked in our stretched system.

Nothing is more illustrative than the story of Daniel, who suffers from a destructive joint disease. In a seemingly innocuous consultation with Whitaker, who has been privileged to witness the course of his illness, Daniel is asked about his mood. The relational comfort leads him to open up with deep answers, culminating in a short note to his GP:

'YOU KNOW I'M NO GOOD AT SAYING THINGS IN WORDS BUT THANK YOU FOR SAVING MY LIFE.'

It is a sentiment borne out in evidence. Continuity of care saves lives.[1] As a GP partner who grew up in a 'traditional general practice' household and believes in the holistic and integrative skill of our specialty, Whitaker's book was a welcome relief. It serves both as a guide for patients and professionals to inform them why the NHS finds itself in its current situation, while hopefully also acting as a wake-up call for politicians and policymakers. It is also a professional call-to-arms.

As well as his wealth of experiences and knowledge, Whitaker draws on his patients' stories and interviews with experts to help his readers engage constructively with the issues he presents. He introduces (among other areas) low-carbohydrate diets, the evidence around the benefits of exercise, and useful guidance around the benefits, risks, and harms of medications.

He also takes us on an indulgent tour of my general practice heroes: the inspiring continuity work by Sir Denis Pereira Gray, Phil Evans, and Kate Sidaway-Lee; the humanism of Iona Heath and Martin Marshall; the pioneering work of Julian Treadwell (re-communicating population versus individual risks); and David Unwin's work on reversing diabetes — we learn about cutting-edge and meaningful thinking in general practice today.

So, am I left encouraged by Whitaker's book? No. I am sad about where we are.