BMJ 2018;361:k1947 doi: 10.1136/bmj.k1947

HEAD TO HEAD

Should GPs' daily number of consultations be capped?

Limits to workload could protect GPs and patients in a system that has become dangerous, says **Laurence Buckman**, but **Michael Griffiths** says arbitrary caps inhibit professionalism and autonomy and might cause harm

Laurence Buckman *GP partner*[1], Michael Griffiths *GP partner*[2]

[1]London, UK; [2]Caerphilly, UK

Yes—Laurence Buckman

If we admit that GPs become less safe the longer they work, we could harm the profession. However, the 10 minute consultation is too short for the amount of work required to meet patients' needs. And the pressure to perform better and longer for more and more patients, with greater degrees of complexity, is now dangerous—for them and us. The time has come when the public has to be told that it is unsafe for them to be seen when the GP is not thinking optimally, and that tired GPs risk harming patients—and themselves through stress associated illness. I am not prepared to die for the NHS.

The first medical commandment is to do no harm. We must no longer squeeze what needs to be done for patients into 10 minutes. We must stop pretending that we can see potentially unlimited numbers of possibly sick people without respite. We must support the BMA's recent call to limit the daily number of consultations.[1]

No limit for genuine emergencies

Of course, we should not limit genuine emergencies, but fortunately these are rare. Most so called emergencies are for minor ailments, certificates, insurance forms, or simple queries, and none of these justifies working into the evening.

Most practices triage their excess workload to allow patients with emergencies to be seen while controlling the deluge of people with problems who are less sick or not sick at all. Every problem is important to every patient, and we should recognise that, but we cannot keep on giving until we might make a potentially serious error or become ill ourselves through overwork. And often the last patient we see is the sickest of all, or a child with anxious parents, who need all our skills.

My day as a principal is typically 12-14 hours long. I know sadly that I do not think as quickly or as laterally at the end of the evening as at the beginning of the day. Like many GPs we start out with a "fixed number" of appointments—18 surgery consultations in each half day—but we also have a policy to turn away nobody who says he or she is in need. We cope with this load. What crushes us is the bureaucracy (repeated referrals for the same problem, obstructive referral management systems, form filling, etc) not the (largely understandable) demand from patients. But, by the time I get home the compassion well has nearly run dry.

Limiting your workload is the sign of a professional, and GPs now need to act. However a practice triages—by phone (which is easier but still requires concentration to avoid mistakes) or in person—the total number of interactions needs to be limited to safe levels. Many GPs stop at two hours a session (about 12 patients) to ensure they have enough time to enter data and think about care. This often creates long waits for patients to see a GP.

My generation can handle it

My generation can still turn it on and keep going until the last straggler has been seen, but perhaps the time has come to stop doing so. We have to engage with a debate that understands that limiting access on safety grounds also risks criticism that we turn away a sick person.

We do not want to open GPs up to more attacks about lack of availability. We must collectively tell patients that there are not enough of us, and there are too many of them. We have tried a host of manoeuvres to control demand (notices in surgeries, local and distant triage, trying to reduce NHS bureaucracy, etc) but they have not held back the flood. We have to tell those who turn the tap that only so much water will go under the bridge today, for their safety and ours. Politicians must also be honest with their voters—we have run out of doctors and time.

No—Michael Griffiths

General practice is a tale of the unexpected. You never know what's coming next. But this has become less true since the 2004 General Medical Services contract, which formally added management and prevention of chronic disease to our traditional role of caring for "people who are ill or who believe they are ill."[2]

Correspondence to: L Buckman l.buckman@ntlworld.com, M Griffiths dickyskin@aol.com

The ability to hand back responsibility for out-of-hours care and the limitation of the "normal" working day were partial recognition of the additional workload that this more proactive approach to patient care implied. Unfortunately, through under-resourced or unresourced movement of care out of hospitals, the extension of clinical governance with onerous inspection regimes, the bureaucracy that surrounds appraisal and revalidation in England (and to a lesser extent in Scotland and Wales), and increasing demands for information, successive governments and management regimes have gradually transferred more work into this GMS funded envelope. This has left the profession feeling overwhelmed by the excessive workload and compromised patient safety.

The unresourced work that is being diverted our way needs to be limited, and one of the ways proposed is to cap the number of consultations a GP can have during a normal working day.[3] This is the wrong way, partly because it limits our flexibility and professionalism when dealing with patients, but mainly because it does not address the question of bringing additional resources into primary care to manage work that we could undertake if properly funded.

Let us set an arbitrary limit of 30 patient contacts in a working day (equivalent to 12-13 minutes per consultation using the old 1990 contract's "red book" guidelines for administrative time). I can see 20-30 patients with upper respiratory tract infection easily in a morning surgery and be ready for more. The trick here is not to miss the early meningitis, pneumonia, or strep throat that may lead to sepsis; so there is a limit, but these are generally 3-5 minute consultations.

What if the 31st patient has chest pain?

But what happens if the 31st patient has chest pain, or is depressed, and leaves surgery so upset by our contractually enforced rejection that he or she attempts suicide. They may not announce themselves as an emergency. Can we really turn them away and call ourselves professional?

Also, we are encouraged to employ other practitioners to manage minor illness, leaving only the more complex cases for the doctor. A morning of psychosocial problems such as the patient who cannot pay the "bedroom tax" and is threatened with eviction; the parent whose child is not performing as expected at school, who wants an assessment for autism or attention deficit hyperactivity disorder; or the mother of five children who is being emotionally and physically abused leaves me emotionally drained. After 10 such cases, I may feel that it is unsafe to continue, but I could be contractually obliged to see a further 20 patients. A cap could become an expected level of work.

Discretion to control workload

In reality, our days are not so clear cut, and we see a mixture of such cases alongside our patients with asthma, diabetes, or hypertension, whose control is such that our nurses feel they should see the doctor. We need the discretion to control this workload—and additional resources that we can call on when we have reached our personal limits. We need the flexibility and the professionalism to decide where these limits lie and support from primary care organisations and government to do this.

We do not need an arbitrary cap. Proposing such a cap may be a useful negotiating tool when arguing for extra resources to manage growing workload, but it should never become an end in itself. That way lies loss of patient access to their GP, loss of professionalism on the part of the GP, and a risk of missing something that is at least as great as continuing to work when fatigued.

What is needed is a greater proportion of NHS resource coming to primary care to enable us to administer our practices properly, allowing the right professional enough time to devote to each patient without feeling exhausted at the end of the day.

Competing interests: Both authors have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 BMA. Controlling workload in general practice. 2018. https://www.bma.org.uk/advice/employment/gp-practices/service-provision/controlling-workload-in-general-practice
2 NHS Employers. Investing in general practice: the new general medical services contract. 2003. http://www.nhsemployers.org/-/media/Employers/Documents/Primary-care-contracts/GMS/Archived-GMS-contract-Changes-2004-2010/2003-2004/Investing-in-General-Practice---The-New-General-Medical-Services-Contract.pdf?la=en&hash=7F830D4747ECD5221C27D990C08BE060299A6DFB
3 BMA. *General practice. The way forward.* BMA, 2016.