A personal view:

The complexity of perfection

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I have long felt frustrated by the many things that others feel I 'must' do in a consultation. I suspect, like other GP's, I end up not doing many of these things, or taking short cuts, and either feel 'guilty' for not being a proper GP, or at risk of being condemned of poor practice in the event that something goes wrong. The spectre of 'medico-legal action' hangs heavily.

My thoughts came in to focus when I was teaching residents in Family Medicine in the USA. Several of them examined asymptomatic men for inguinal hernias. This was not 'wrong' in any absolute sense but there had to be reasons why I never do it.

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Questions

- What is a 'must do' in the consultation?
- What is a 'could do' in the consultation?
- What evidence is needed to prioritise consultation tasks?
- In any single consultation, are there things that we do that are less value to the patient than things that we miss out?

Assumptions

- There is not enough time to do the 'perfect consultation'; something(s) will get missed out
- Our job is to do the most effective job given the time and resource available
- The more 'must do's' the less time for 'could do's'
- It is impossible to avoid risk

The Content of the Consultation

There are a number of 'must do's' in any consultation. The size of this category will be a matter of opinion but the minimum will include:

- Greeting and establishing rapport with patient
- Sufficient history to establish reason for visit
- Sufficient examination to make a diagnosis and exclude 'red flags'
- Completing forms for patient requirements; ACC, WINZ, prescription
- Documentation for funding purposes.

I won't attempt to document all that might be included in the 'ideal' consultation, but some things would be:

- A more extended effort establishing rapport (how's your mother? Is your new house comfortable?...)
- Screening; cervical cancer, diabetes, colorectal cancer, breast cancer, hypertension...
- 'Complete' examination
- Public health; family violence, immunisation, smoke detectors in house, child car restraints
- Psychosocial; alcohol/drug use, family relationships, stress management
- Detailed data gathering for audit purposes; coding consultations, demographics, next of kin etc.

I work in a practice with many high need patients that is 90% funded from government sources. There is a significant gap between the time available to do the work and the work to be done so I have been forced to question the validity of some of the conventional 'must do' tasks. Here are some examples.

Chest examination

I do about four different sorts of chest examination.

The first is when the patient has come with a history consistent with a viral URTI, with no co-morbidity and very unlikely to be have alternative diagnosis. 'I want you to check my chest'. The reason to put stethoscope to chest is to retain patient confidence. It is extremely unlikely it is going to alter management so I will do it as quickly as possible to achieve that goal, usually without undressing and often without listening to the back.

The second is similar to the first except that there may be a specific feature to determine; for example is there wheeze or not?

The third is more extensive in someone with chest pathology, say controlled CHF. I will undress more and examine the whole chest.

The fourth would be in the sick person for whom I am unsure of a diagnosis other than it is related to the chest and I will do an examination that (I hope) the Primex examiners would be proud of.

How much of an examination I do is determined by a combination of time availability, an assessment of

the risks of not doing a full examination, and of the benefits (will it change management) of a fuller examination. Only in retrospect is there a right or wrong level of examination. There is little 'evidence' in the literature to guide my decisions; I rely on my 'art' and experience.

Administering flu vaccine

At this time of year more time has to be found to give the fluvax. It can take anything from one to 30 minutes depending on how much talking you do. There are detailed guidelines that include informed consent, checking for allergy to eggs and having access to adrenaline and CPR training, and then documenting the site of administration and batch number. Finally the patient is supposed to be observed for 20 minutes afterwards. The major difference between the one minute and 30 minute version is covering for the risk of an anaphylactic reaction. The protocols in the immunisation handbook declare the 30 minute version to be 'must do', but fail to provide the evidence for this let alone detailing any evidence to guide variation.[1]

My belief is that the risk of anaphylaxis in someone with no history of any allergies and who has previously had a fluvax is so low that I can ignore it, so I do the one minute service. It should be possible to produce evidence around this but those writing the protocols have formed the view that we should aim for 'perfection' no matter what the cost. If I followed the protocol fewer patients would be vaccinated and in particular my house bound patients would not be vaccinated. We cannot afford to send out two people to spend 30 minutes at each house to give fluvax.

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Screening for hepatocellular carcinoma

There are numerous guidelines on management of chronic viral hepatitis that recommend regular alpha-feto protein and ultrasound scan to detect hepatocellular carcinoma.[2,3] None that I have seen document what benefit is likely if these guidelines are followed. They also make no mention of the inability of the public health system to do the large number of ultrasound screens that would be required. Since looking into this I found a comprehensive review article that concludes that currently there is not the evidence to support such screening.[4] In short we are told that this is a 'must do' when in fact there is no evidence of benefit in doing it.

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Screening for asymptomatic inguinal hernia

I initially remonstrated with the American residents arguing that they should not screen for asymptomatic hernias. This fell on deaf ears, they had been taught it as part of a thorough check up and Americans like their annual checks. However it was always possible to suggest something that they had not included in the consultation that they agreed had more value than looking for a hernia.

Running a business and CME

If it is true that we do not have enough time in the consultation, it is equally true that there is not enough time in the rest of the day. I have only so many hours to apply to reading and learning, and any time and money spent on 'business compliance' or responding to new structures of care is time and money that is not spent on patient care.

Pharmaceutical schedule

I have to be familiar with the pharmaceutical schedule. If I am not I add extra (unpaid) work to the lives of my pharmacist colleagues and have to receive and amend prescriptions that do not meet the regulations. The recent change from monthly dispensing to mostly three monthly dispensing has caused me much frustration. If I had been designing the system I would have just allowed GP's to make their own judgements on what was best for each patient. It is a pain having to consult a list to see whether the drug I am prescribing fits the new category or not. I cannot see why, if I have specified monthly dispensing or the medications are blister packed or are drugs of addiction with daily pickup, I must also write 'close control'. It is truly over the top that I have to initial any of the 'close controls' that I have written. The more complicated the regulations are the more likely it is I won't remember them and that it will cause strife for my patient, the pharmacist and me.

This change was particularly galling. Some years ago they changed to monthly dispensing to save money because of medicine waste. Now they are changing to three monthly dispensing because monthly dispensing ended up more expensive. Maybe if they just provided us with the information on what the system was costing and asked us to bear this in mind when prescribing we might be able to find the most cost effective prescribing pattern without all these time consuming regulations.

Washing blood pressure cuffs

We have instituted a quality improvement programme that goes through all the processes of our work place and looks at ways things could be improved. I discovered this week that our infection control policy says that we should wash our blood pressure cuffs regularly. I can

see the merit in this but it is something that we do not do and I am not sure what benefit to our patients will accrue if we start doing it. There are aesthetic issues as well as possible infection control issues. Aesthetics are largely managed by how the cuff looks. If it looks clean then I have never met someone objecting to my using the cuff on him or her, when they know full well that it has been used on other patients without cleansing in between. I am pretty sure that there is no literature that demonstrates increased infection rates in GP surgeries that do not wash their cuffs.

Working on our quality programme has added more things to do in the day (week, month, year). Many of the changes we have made were great, gained improvement for little input. There is a cost in the time spent writing and reviewing protocols. Most of these programmes do not attempt to measure the quality of the individual consultation because it is too hard. The problem is, that is the most important thing that we do. A practice that scores well on all the quality measures could still have some poor practitioners there.

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Alcohol swabs and vaccinations

Normal practice used to be that the site of an injection would be swabbed with an alcohol swab to 'clean it' prior to giving the injection. This seemed the right thing to do. If you were breaking the skin barrier then cleaning the affected skin beforehand was necessary wasn't it? This is no longer recommended because a proper study was done that demonstrated that swabbing increased problems if the alcohol was not left to dry prior to injecting (which is what usually happened) and no harm was found for those who were not swabbed.

The moral from this tale is that just because we have always done something and that it seems logical, it does not mean that it is the right thing to do.

Community services cards

Fortunately these are on the way out but prior to becoming an Access PHO we all spent hours checking these cards. If we didn't, then we got less money. A pharmacist colleague was audited recently. He had money deducted from one script because the person involved did not hold a card at the date the script was dispensed. They held one two weeks before and two weeks after. It was well established that many people eligible for a card do not have one and the expiry time on some of the cards is very short. The people setting this system up did not pay adequate attention to the compliance costs to practices and patients of maintaining these cards. This is particularly an issue because many of those eligible have difficulty getting access to anything because of illiteracy, English as a second language, personality disorders etc. The new system of geocoding to the deprivation index score from census data is a great improvement.

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Conclusion

As GP's we have to come out of the closet and stop pretending that we do 'perfect' consultations. The judgements we make of what to include and what to exclude are the essence of our specialty and we should be proud of the short cuts we make, in achieving the best care and outcome for our patients within the resources available.

We need to push for better evidence from those wanting to add 'must do's' to our day. This needs to not only show benefit of the proposed intervention but also the detail and quality of the evidence so we can assess the relative priority of the intervention.

We need to challenge all agencies to think very carefully before they add 'must do's' to our day. Is the benefit of this new thing proven, and if it is, is it of more value than the many 'could do's' that will be shunted out? In particular the various bureaucracies that we engage with need to understand that the more requirements they push on to us the less time and resource is available for our patients.

There is a danger in the current movement towards practice accreditation and continuous quality improvement that we will spend more time doing things of relatively low value but that are easy to measure at the expense of spending time with our patients doing valuable things that are hard to measure.

References

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