



VIEWS AND REVIEWS

NO HOLDS BARRED

Margaret McCartney: Why GPs are always running late

Margaret McCartney *general practitioner*

Glasgow

An intelligent, kind friend says to me, “My GP is always running late—why?”

I try to explain that her GP is probably similar to me. Even arriving early and staying late, I still only have about 12 minutes for each patient. And I have to fit a lot into those 12 minutes.

I must go to the waiting room to locate and invite the patient into a private room. I must introduce myself and find out why the patient’s here. There’s probably more than one reason.

Then, history taking: sometimes complicated, sometimes not. Examination, if needed. Assistance may be required. Clothing may need to be removed. A chaperone may need to be sought. Clothes replaced. Laces retied. Hands washed again.

Blood tests or swabs. These need forms and sticky labels. A multitude of computer clicks and whirrs. What antibiotics did the patient last have? When?

Click.

The next screen wants the same information again. And, again, you’re looking at the computer, not the patient. Time’s ticking away. The information sheet you’re trying to print isn’t printing.

Click, click, click.

Next, discussion. Here are the options. This is what I think; what do you think? Let’s plan. This should be the best bit, but messages may be flashing up. You need to remind the patient how the results will come. The telephone number on record is wrong and needs changing.

Another computer alert—the patient’s blood pressure needs to be rechecked. This is meant to be done in both arms, with the patient relaxed. But you yourself are not relaxed, and you try not to infect the patient with your plight.

Intercurrent and ongoing issues may need discussion, such as other chronic diseases. Social issues, housing problems. Stress is common, as are loneliness, joblessness, and bereavement.

Then, of course, I’m ideally placed to identify and discuss incidental obesity, domestic violence, physical activity, cyberbullying, and sexual problems—and to promote cancer screening and inquire about alcohol excess, or whatever else this week’s awareness campaign is about. Polypharmacy is common, as are medicine queries and uncertainties: medicines should be routinely reviewed and choices discussed.

And then comes the moment when you have a bit of eye contact, or a pause or change in tone, and the patient now feels able to tell you what it is she or he really wants to talk about.

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As a colleague puts it, general practice is based on a lie—a lie that we can do this safely and well in 10 minutes. I reckon that acceptably safe practice would take double that, and excellent practice would need more again to ensure that everything’s in place for proper, shared decision making.

No one goes into medicine for an easy life. But I’m haunted by a feeling of persistent failure. We need to know: what expectations can we realistically have of the time currently available to us—and how much more time and resources should we really have to do it well?

Competing interests: See www.bmj.com/about-bmj/freelance-contributors/margaret-mccartney.

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

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