The Patients Association

listening to patients, speaking up for change

Primary Care

Patients and GPs - Partners in Care?

September 2012

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Foreword

When the media, charities and decision makers talk about the areas in which the NHS fails patients their focus is typically on the areas of acute or adult social care.

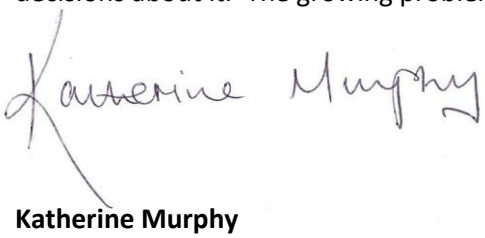
Yet nine out of every ten contacts that a patient has with the NHS will be through the primary care sector. Here, as everywhere else in the NHS, the vast and overwhelming majority of care and treatment is delivered superbly by dedicated clinicians.

However, as in the rest of the NHS, the small minority of cases of bad care translate into large numbers of patients that, for a multitude of reasons, have cause to be dissatisfied with the contact they have with the primary care sector.

It is clear that this is a problem that is growing. The recent GMC complaint figures, as well as the increase in calls we receive to our Helpline regarding primary care, all indicate this. Partially this increase can be attributed to the breakdown in the traditional relationship between clinicians and patients. We now live in a consumer society and are not willing to accept poor service.

However it is equally clear, as set out in this report, that the standard of care being provided on some occasions goes beyond 'poor' and is actually rude, disrespectful and harmful to the patients' health. Whatever the reason for the increase in patient concern about primary care, the concerning findings of our work, as well as the supporting evidence published by other bodies, show that they cannot be ignored, and action has to be taken.

I hope that this report will act as a wakeup call to the Primary Care sector and those that make decisions about it. The growing problems within it cannot be ignored any longer.



Katherine Murphy
Chief Executive, the Patients Association

Executive Summary

- General Medical Council show increase 23% increase complaints about doctors, 47% of which relate to GP's;
- 26% of calls to our Helpline relate to communication in Primary Care;
- 12% relate to concerns about referrals from the Primary Care to the Acute Care Sector;
- 10% relate to patients being removed from their GP's list after making a complaint;
- 39.3% of respondents to our survey say they rated their GP's communication skills at five out of ten or less;
- Only six out of ten patients believe their GP treats them with compassion;
- 80% of patients said they wanted to be more involved in their care.
- Nearly one in four of patients that raised concerns with their GP felt they responded poorly;
- 4.4% of respondents said they had been removed from their GP's list after making a complaint;
- Surveys show the removal rate for patients from their GP list to be 4.3 per 10,000 patients.

Call to Action

Communication

- Communication skills to be part of the evaluation process for revalidation and for the GMC to set clear benchmarks for doctors to meet in communication skills;
- The way that doctors involve patients in their care also needs to be monitored. Only 55.7% of patients felt they were involved in their care, and 80% wanted to be more involved.
- The CQC to use its inspection process to detect poor communication and recommend improvements.

Referrals

- The NHS commissioning board to make a clear statement against the rationing of services, and to take action where it is clear that services are being rationed on the basis of cost rather than clinical effectiveness.

Deregistration

- The GMC to put in place a new definition of what a 'breakdown' in the relationship between the GP and patient would consist of;
- Action to be taken, in the form of sanctions, against those GP practices that continue to defy existing guidance and remove patients from their list after they raise a concern.

Integration

- Priority should now be given to developing integrated care models before CCG's start the process of commissioning services.

Introduction

It is beyond dispute that the Primary Care sector is facing its biggest shake up since the formation of the National Health Service.

The advent of GP led commissioning will place new burdens on those clinicians, who, as well as continuing with their existing responsibilities (i.e. making patients better and sign posting them to appropriate services) will also be responsible for the management of huge budgets.

As we have previously argued, this will fundamentally alter the relationship between clinicians and patients in primary care. Instead of faceless 'bureaucrats' based at the Primary Care Trust offices making the decision to deny a patient life improving treatment, it will be the doctor sat in front of them.

It is a fair assumption that this change in relationship will lead to a more difficult doctor-patient relationship. So it is deeply concerning that we are seeing strong indicators that the relationship is already in decline. Unless we have an in depth and detailed discussion of the issues now, that decline might become terminal.

Twenty six per cent of the patients that contact us in relation to the Primary Care system tell us that they have concerns about the way their doctors communicate. This is supported by the GMC's figures which show a huge increase in concerns about communication and GP's failing to treat patients with respect.

However the introduction of revalidation for doctors represents a fantastic opportunity to tackle this problem, which is why we are calling for communication skills to be part of that appraisal process.

The Care Quality Commission (CQC) has also taken on responsibility for inspecting GP practices and ensuring good quality Primary Care is being delivered.

Communication is vital to ensuring that good quality. The CQC must use its inspection process to detect poor communication and ensure that it is improved, engaging directly with patients and their experiences.

Our own research, and a multitude of external sources, have demonstrated that the number of procedures of supposed 'low clinical value' taking place are declining. At the same time more patients are contacting us to tell us that they are not being referred to acute services, in cases where they strongly believe it is justified.

We are concerned that this is a situation that will only get worse once Primary Care Trusts transfer their powers and functions to Clinical Commissioning Groups (CCGs). The role of the NHS commissioning board is vital in ensuring that this is not the case.

We are calling for the NHS Commissioning board to make a strong statement of intent that it will take action where required to prevent rationing occurring.

In our 2011 report into poor elderly care we said, "If the complaints system is stopping patients from complaining, it is hindering the ability of the NHS to listen and learn". This is equally true of primary care. One of the great unspoken scandals of the NHS is that the risk of being removed from your GP's list because you make a complaint against them deters many patients from doing so. This is despite this practice being widely condemned by doctors groups and the Parliamentary and Health Service Ombudsman. Our survey showed that 4.4% of patients have been removed from their list, and 21% of complaints about GPs to the Ombudsman relate to inappropriate deregistration.

Patients that contact our Helpline frequently tell us that they are concerned about the behaviour or competence of their GP, but do not wish to complain as they are concerned that they, and their family, may be removed from the practice list.

We would urge the GMC to put in place a more thorough definition of what a 'breakdown' in the relationship between GP and patient would consist of. Where this guidance is ignored, we believe the Department of Health should put in place sanctions similar to those that it charges to trusts that use mixed sex wards.

Many patients experience a lack of joined up care when moving between the primary and acute sector. In particular many patients and carers experience communication problems from both sectors when trying to obtain information on progress of their treatment, or diagnostic tests such as blood tests and X-rays.

Improving integration of care would be one of the biggest contributions that the health and care services could make to improving quality and safety for patients.

Priority should now be given to developing integrated care models before CCGs start the process of commissioning services.

The problems we see in primary care are difficult to tackle, and long term solutions require a change in culture and a long term recognition that patients should not simply have to accept poor service from their GP. However this makes it even more important that decision makers in the NHS take heed of the warnings set out in this and other publications, and begin to resolve these problems now, before the primary healthcare landscape changes forever.

Background

The vast majority of patient interactions with health services are with primary care. The Department of Health in England estimates that as much as 90% of all contact in the NHS between patients and health services is in a primary care setting.[1]

Primary care includes:

- Primary Medical services and GP Services;
- Dentistry;
- Community Pharmacy; and
- Eye care services.

It is defined as health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment.[2]

There are around 36,000 GPs working in 8,200 GP surgeries in England alone along with 22,000 practice nurses and 5,000 care assistants[3] who between them provide care in 300 million patient consultations every year.[4]

For the first part of a continuing series we will be concentrating on primary medical services and in particular the work of GPs, as that is the main reason people contact our Helpline to discuss primary care.

Structure

Until recently, GP services were operated by Primary Care Trusts who provided strategic direction and commissioned services requested by GPs. However, under the Health and Social Care Act 2012, these structures are going to be fundamentally altered.[5]

Primary Care Trusts are to be abolished and the job of commissioning services will be passed to GPs who will be obliged to group together as Clinical Commissioning Groups (CCGs). These in turn will be overseen by the NHS Commissioning Board which will operate at arm's length from the Department of Health. CCGs will be led by GPs and will be responsible for handling around 60% of the NHS budget, commissioning the vast majority of services for patients. They will only be able to do so once they have been authorised by the NHS Commissioning Board. All GP surgeries must be part of a CCG by April 2013 but will only be authorised to undertake their commissioning responsibility when they are "willing and able" to do so.[6]

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[1] Department of Health (2012) Primary Care. Available at http://www.dh.gov.uk/health/category/policy-areas/nhs/primary-care/ (Accessed 19 September 2012)
[2] "primary care". Oxford Dictionaries. April 2010. Oxford University Press. 18 September 2012
[3] The NHS Information Centre. (2011) General and Personal Medical Services: England 2000-2010 (as at 30 September). London.
[4] Hippisley-Cox J, Vinoggradova Y. (2009) Trends in consultation rates in general practice 1995/1996 to 2008/2009: analysis of the QResearch database. London: QResearch and The Information Centre for Health and Social Care.
[5] Health and Social Care Act 2012. London
[6] Williams, L. NHS Commissioning Unit. Department of Health (2012) Our NHS care objectives: A draft mandate to the NHS Commissioning Board.

There have been concerns that the move to GP led commissioning may damage the relationship of trust between GPs and patients which is very important for effective communication and medical care. At the time of her appointment in 2010 when the debate on the Health and Social Care Act was still ongoing, Professor Clare Gerada, Chair of the Royal College of General Practitioners commented saying:

"At worst, the negative impact for GPs could be patients lobbying outside their front door, saying, 'You've got a nice BMW car but you will not allow me to have this cytotoxic drug that will give me three more months of life. I'm concerned that my profession, GPs, will be exposed to lobbying by patients, patient groups and the pharma (sic) industry to fund or commission their bit of the service. There could be letters from MPs and patient groups, and begging letters from patients."[7]

At present, patients must live within the catchment area of a practice in order to be registered there. However, the Department of Health has recently consulted on measures that would allow patients to register with the GP practice near where they work or where their children go to school for example to make it easier for them to access services.[8] There has been opposition from some doctors' groups who say that it risks unbalancing health services and making the job of commissioning harder.

Current Policy

Following the passage of the Health and Social Care Act in March 2012, GPs have been moving towards taking on their responsibilities as discussed above. However the day to day work of GPs, talking to and treating patients, remains as important as ever.

As part of its aim to make savings of £20 billion by 2014 (what has been called "The Nicholson Challenge"[9]), the Department of Health has put in place the QIPP programme - Quality, Innovation, Productivity and Prevention –which it says will improve the quality of care the NHS delivers while making up to £20billion of efficiency savings. The programme includes GPs and sets targets for spending which are the basis on which the NHS is expected to contain rising costs and stay solvent. For that to work, GPs must adopt innovative approaches to healthcare in productive ways, preventing people with long-term conditions from deteriorating, while providing good quality care. They are also primarily responsible for public health and the prevention of illness.

In his annual report on the NHS, Sir David Nicholson, the Chief Executive of the NHS, reported that the NHS in England has reached its target of making £5.8 billion in savings in 2011-12.[10] The QIPP agenda has been criticised as being cuts in disguise. Jim Easton, Director of Improvement and

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[7] Campbell, D. (2010). 'Doctors warned to expect unrest over NHS reforms'. The Guardian, 19 November 2010 [online]. Available at http://www.guardian.co.uk/society/2010/nov/19/doctors-warned-expect-unrest-reforms. (Accessed 21 September 2012)

[8] Department of Health (2012). Liberating the NHS: No decision about me, without me - Further consultation on proposals to secure shared decision-making (available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134218.pdf)

[9] Ball, D (2009) 'NHS chief tells trusts to make £20bn savings', The Telegraph, 13 June 2009 [online]. Available at http://www.telegraph.co.uk/health/healthnews/5524693/NHS-chief-tells-trusts-to-make-20bn-savings.html (accessed 21 September 2012)

[10] Nicholson, D. Department of Health (2012). The Year: NHS Chief Executive's annual report 2011/12, including The Quarter, Quarter 4 2011/12. London

Transformation at the NHS Commissioning Board warned that is some areas the QIPP was increasingly being seen as cover to make cuts to services.[11]

In June 2012, the Royal College of General Practitioners (RCGP) published its report, *Medical Generalism: Why expertise in whole person medicine matters,* which looked at the vital contribution that medical generalists, like GPs, make to medical practice and patient care.[12] It was written in response to the findings of the Independent Commission on Generalism which was established by the RCGP in March 2011 alongside the Health Foundation. The RCGP has said that as the "front door" of the NHS, generalists have a vital role to play particularly as elderly care becomes more complex.

Ten key areas the RCGP would make a priority were also identified in order to ensure that the College was able to adapt to the needs of patients as they changed. These were:

- Effective use of patient feedback;
- Policy on out of hours care;
- Development of generalist models of care for complex and chronic conditions in the community;
- Improved communication between GPs and specialists;
  Extended training for GPs;
- Enhanced training in paediatric care, learning disabilities, mental health, palliative and end of life care;
- GP-led commissioning;
- Further research into multiple morbidities and early, accurate diagnosis in primary care;
- Use of IT, data sharing and inter-agency e-communications;
- Nursing home care.

The RCGP has also, at the time of writing,[13] launched a consultation on its vision for the future of general practice up to the year 2022.[14] The College wants to see increased numbers of GPs, longer and more specific training for GPs and more work done on how the current role of GPs can be changed to improve services and outcomes for patients.

They suggest that the role of "gatekeeper" to NHS services will become less important as patients become more able to access services such as physiotherapy and talking therapies through self-referral. Instead, GPs will become interdisciplinary leaders and community generalists.

[11] Williams, D. (2012) 'Easton: we must tackle cost-cutting masked as efficiency'. Health Service Journal, 26 July 2012 [online]. Available at http://www.hsj.co.uk/news/finance/easton-we-must-tackle-cost-cutting-masked-as-efficiency/5047475.article (Accessed 18 September 2012)

[12] Royal College of General Practitioners (2012). Medical Generalism: Why expertise in whole person medicine matters.

[13] September 2012

[14] Royal College of General Practitioners (2012). RCGP Consultation - Better care for patients: defining the role of general practice in 2022 – a call for action. Available at http://www.rcgp.org.uk/pdf/2022%20Consultation%20document.pdf (accessed 21 September 2012)

Integration of services is becoming increasingly important as more patients with multi morbidities put pressure on NHS services. The RCGP believe that GPs have a vital role in integration ensuring good communication between providers and coordinating care to ensure that patients do not get lost in the system and receive the care they need, when they need it.

However, at the same time, the number of complaints being made against doctors, and in particular GPs, is rising. The General Medical Council (GMC) which regulates all doctors has reported a 23% rise in the number of complaints made against doctors in the UK.[15] Nearly half (47%) of those complaints were about GPs as opposed to other doctors. The increase is not isolated and is part of a 69% rise in the number of complaints made against doctors in the last 3 years.[16] The GMC put this rise down to better reporting mechanisms and increased numbers of doctors raising concerns about colleagues. The fastest growing area of concern was around communication skills and rudeness.

Furthermore, the Health and Social Care Information Centre (HSCIC) found that in 2011-12 there had been 54,870 written complaints about general medical services, a rise of 8.2% from the previous year.[17] The HSCIC reported that the most common reason for complaint was clinical issues with 35.4% and the second most common reason for complaint was communication skills which attracted 21.7% of complaints.

It was also recently revealed that the authorisation of CCGs is to be pushed back and even when they are certified, many will have restrictions placed on their ability to commission services and operate fully.[18] This has led to questions as to whether primary care is ready for the changes coming and how patient care will be affected.

[15] General Medical Council (2012) The State of Medical Educations and Practice in the UK 2012. London.
[16] Ibid 15
[17] Health and Social Care Information Centre (2012) Data on Written Complaints in the NHS, 2011-12.
[18] West D (2012) 'CCGs face temporary limits on authorisation'. Health Service Journal 13 September 2012. Available at http://www.hsj.co.uk/news/commissioning/ccgs-face-temporary-limits-on-authorisation/5049134.article (accessed 25 September 2012)

Methodology

An audit of Helpline data was undertaken by the Patients Association to identify trends and patterns of patient experience in primary care.

As discussed elsewhere in this report, the Helpline has seen a significant increase in the number of people contacting us to raise concerns about their experience of primary care. We looked at this increasing trend in more detail and determined that the trends contained within the increase showed that the key issues were:

- Communication and respect between GP and patient
- The integration of services between primary and acute care
- Patients feeling that they were not being involved in their care.
- Removal from the GP list after making a complaint
- Difficulties and concerns around referrals.

The Patients Association undertook a snapshot survey of patients and the public. The survey asked patients and the public about their experience of GPs' communication skills and whether they had been removed from a GP practice list.

We have also examined other reports that have been published relating to primary care. In addition, towards the end of the process, the GMC report into doctor complaints was particularly important evidence against which we could test our assumptions and the finding of our survey.

Key Issues

The Patients Association Helpline receives 8,000 calls each year.

Patients who have contacted the Patients Association Helpline have told us about a variety of problems with the service they have received from their GP. This included patients who encounter communication issues with GPs, issues with GP referrals and second opinions and issues with GPs removing patients from their lists without adequate reason or explanation. In 2011, 11% of calls to the Helpline were about GPs and in the 6 months from January to June 2012, 25% of calls related to GPs.

Between January and June 2012 the most common issues that led to patients contacting our Helpline were:

Communication with GPs – 26% of calls

Not being given enough information about treatment or follow up appointments. Appearing unsympathetic, unwilling to listen or not allowing patients to discuss the information and conditions that they need to.

Referrals – 12% of calls

Unable to secure a referral that they as a patient believe that they are entitled to, or having to chase the GP to do it after they have agreed. We are concerned that doctors are failing to communicate with patients about their care.

Deregistration from GP lists – 10% of calls

Removed from GP lists without warning, many after having raised a concern. Struggling to get back onto practice lists.

Integrated Care- 3% of calls

Patients concerned that the progress of their care, or their ability to gain information about it, is comprised due to a lack of integration between primary and secondary care.

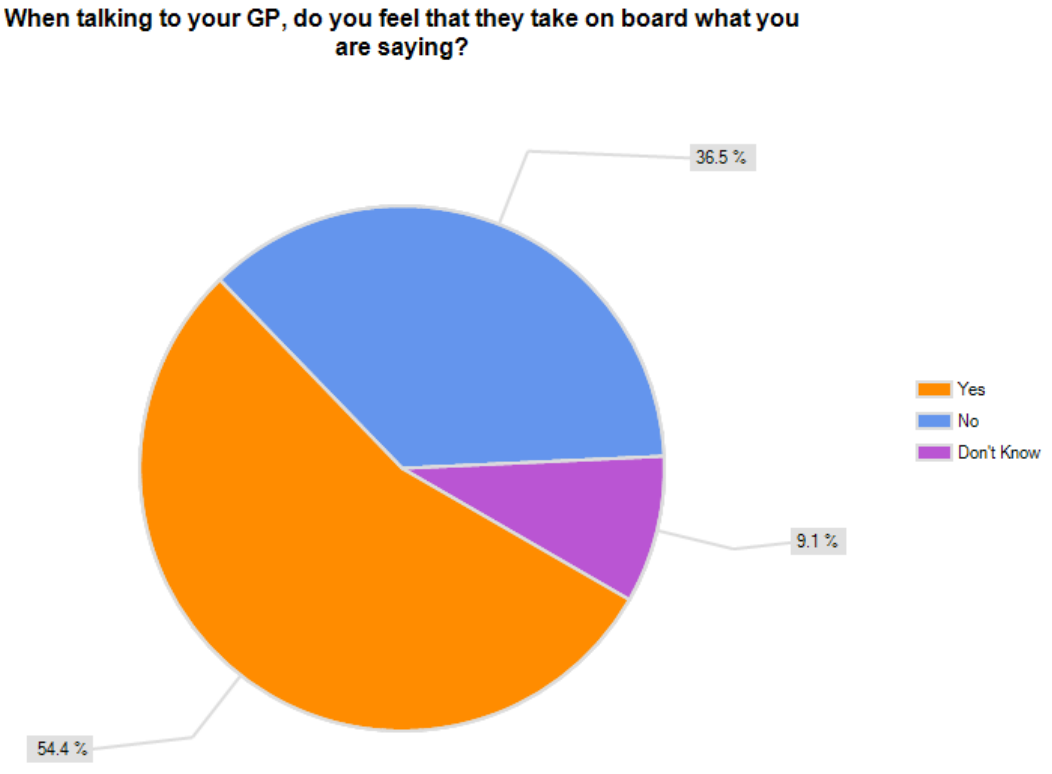
Communication

Communication skills remain one of the biggest issues that patients contact the Helpline about with 26% of calls about GPs relating to communication and compassion. For GPs, this encompasses their ability to provide meaningful information, ensuring patient understanding of their care and treatment, and talking to patients with compassion and understanding. This also includes given patients enough time to adequately discuss their concerns.

Patients frequently contact the Helpline concerned and upset because they do not feel that their GP is listening to them or taking in what they are saying. One patient who contacted us, Patient B, has an ongoing thyroid problem which she has seen her GP about on many occasions. She would like to see a particular consultant who she knows to be good and is comfortable with. This consultant has been recommended to her and is an expert in their field. Patient B's GP will not refer her to this consultant. Patient B cannot see this consultant without a referral from her GP. Her GP will not listen to her and she is particularly worried about this. Her GP is willing to refer her to another consultant, but is not willing to listen to Patient B's concerns.

Our snapshot survey of patients asked whether they felt that their GP was taking on board what they were saying. It found that while the majority (54.4%) of patients felt that they were taking on board their concerns, a significant number (36.5%) did not net feel that their GP was listening. When added with the don't knows 45.6% of respondents did not feel their GP was listening to them (fig 1).

Fig.1



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In our 2011 report, *Information, What Information? Information Challenges of Shared Decision Making,*[19] we also asked patients whether they felt their healthcare professional was taking on board what they were saying. Only 51.7% of respondents said that they felt that their views were being taken into account. Those who said they were not comfortable in these situations said that more time with their healthcare professional and their clinician making more effort to put them at ease would help. The results from these two surveys make a potent argument for the need for change.

We are rightly moving towards a health system which puts patients at the centre of care. Indeed the Department of Health has been repeating the mantra "no decision about me, without me" since the Coalition Government came to power.[20] Shared decision making and co-production have become the biggest buzzwords of modern healthcare. However, it will be impossible to do so if health professionals, and particularly GPs with whom the vast majority of patient interactions and care decisions take place, are not able to communicate effectively with their patients.

Our survey results suggest that there may be some way to go before this becomes a reality. While the majority of respondents (83.5%) felt that they understood what their GP was telling them, when asked to rate their GP's communication skills, the results were very mixed (Fig 2).

While just over half of respondents (52.9%) rated their GP's communication skills at least 7 out of 10, 39.3% rated their GP's communication skills below 5, with 9.6% only giving a rating of 1 (the lowest rating). Looking at the ratings across the board the picture is very confused with no definitive rating standing out.

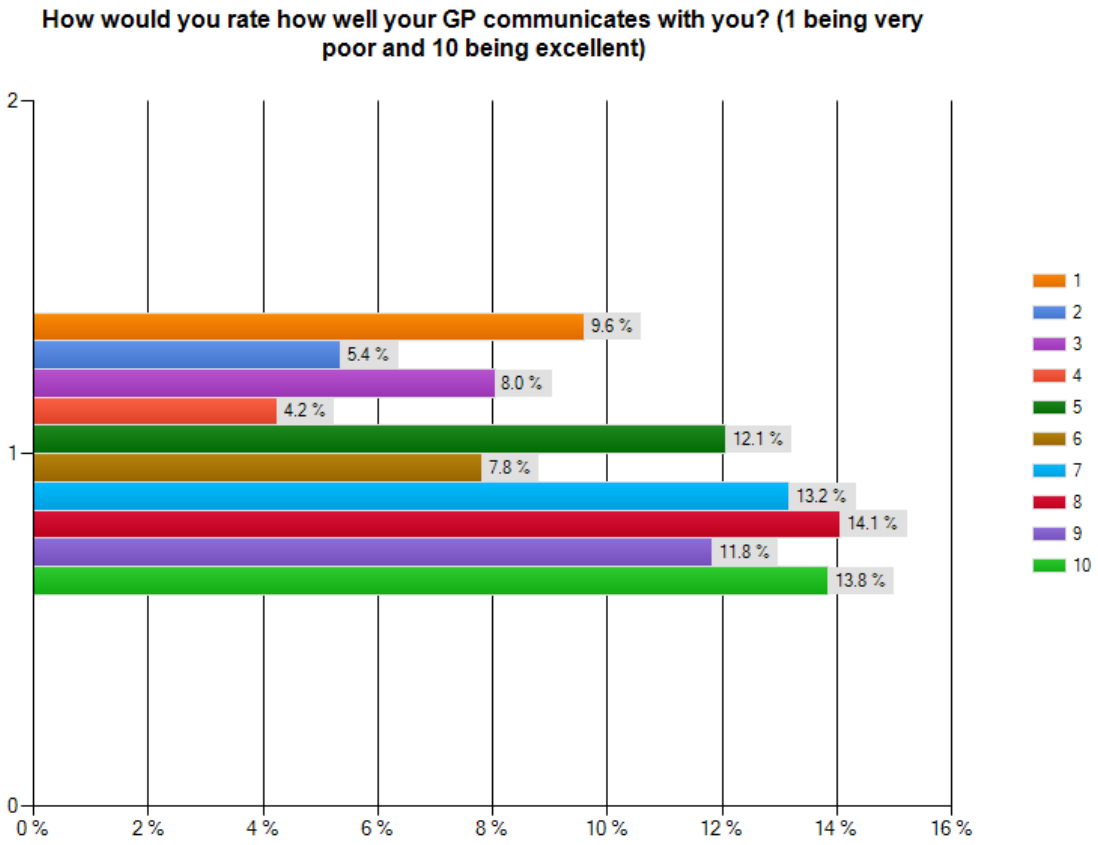
With the GMC receiving a 23% increase in the number of complaints they receive about doctors in the last year and a large proportion of these relating to communication and rudeness,[21] it is clear that significant work is needed to improve the communication skills of doctors.

This is borne out by the cases the Patients Association Helpline hears about. One patient that contacted us, Patient G, told us that she has experienced her GP being rude and dismissive of her medical concerns. Patient G is extremely concerned that her doctor's negative and rude attitude may be expressed on her medical notes. She is concerned that his negative attitude could reflect badly on her and effect the way in which her GP writes on her medical notes. Patient G is fearful that these notes may influence the way that other medical professionals treat her, therefore hamper the care which she needs and deserves. These types of concerns are reflected in our survey with only 58.8% of respondents saying that their GP treats them with compassion.

The NHS constitution makes it clear that as a patient you have, *"The right to be treated with dignity and respect, in accordance with your human rights."* [22]

[19] Patients Association (2011), Information, What Information? Information Challenges of Shared Decision Making
[20] Ibid 8
[21] Ibid 15
[22] Department of Health (2012), The NHS Constitution for England - 2012

Fig. 2



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During the review of a patient involvement tool, the Patients Association undertook a snap survey of a sample of GPs about how they felt they performed in various areas, including communication.[23] While the majority (69.5%) felt that they explained treatments in discussion with patients at least very well and 78.2% said they gave out information in at least a fairly good way, there is still a significant number who recognise that there may be issues with how they approach communication.

A key aspect of communication is ensuring that patients are involved in decisions about their care. Patients who are involved in decisions about their care are more likely to follow medical advice,[24] and report better outcomes from treatments.[25]

However, despite this it is clear that many patients are not fully involved in decisions about their treatment and care. In our survey, 55.7% of respondents stated that their GP involved them in decisions about their care and a further 80.1% said that they wanted to be more involved in decisions (Figs. 3 and 4).

[23] Patients Association (2012) The GP Checklist: A Review. London
[24] Marinker M (1997). Working Party – From Compliance to Concordance: Achieving shared goals in medicine taking. London: Royal Pharmaceutical Society of Great Britain
[25] Stewart MA (1995). 'Effective physician-patient communication and health outcomes'. Canadian Medical Journal, vol 152, no 9, pp1423-33

Fig. 3

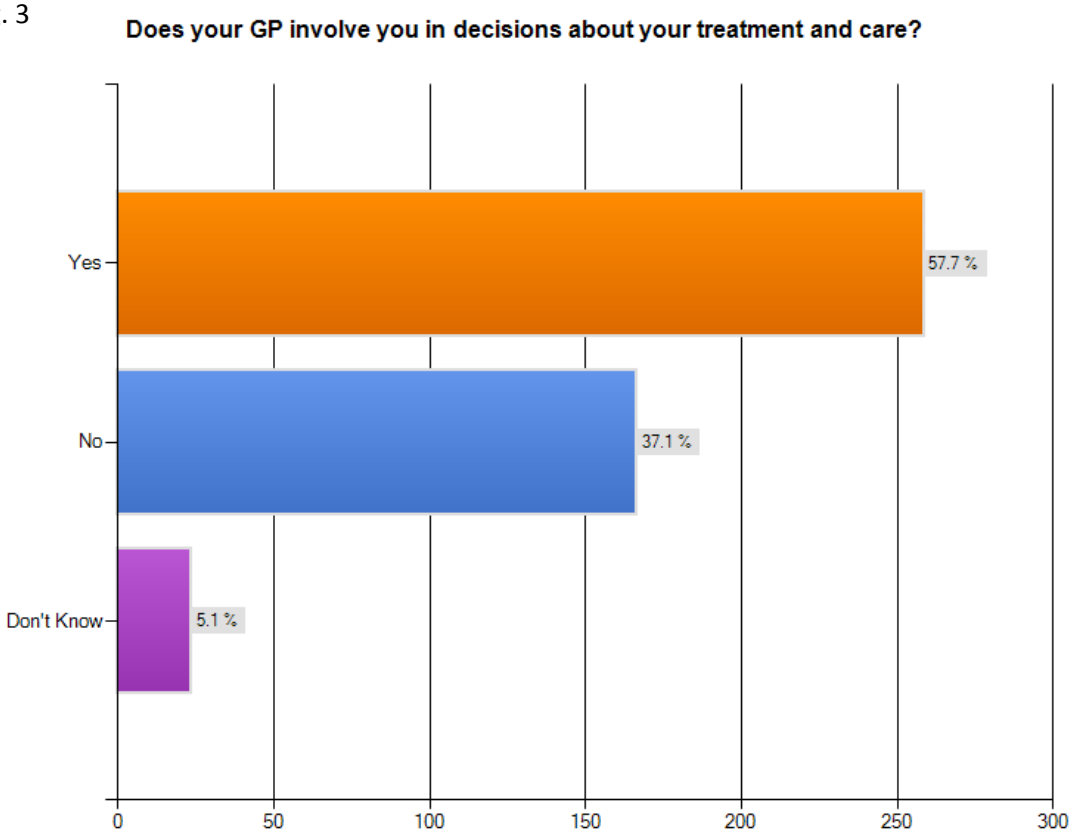

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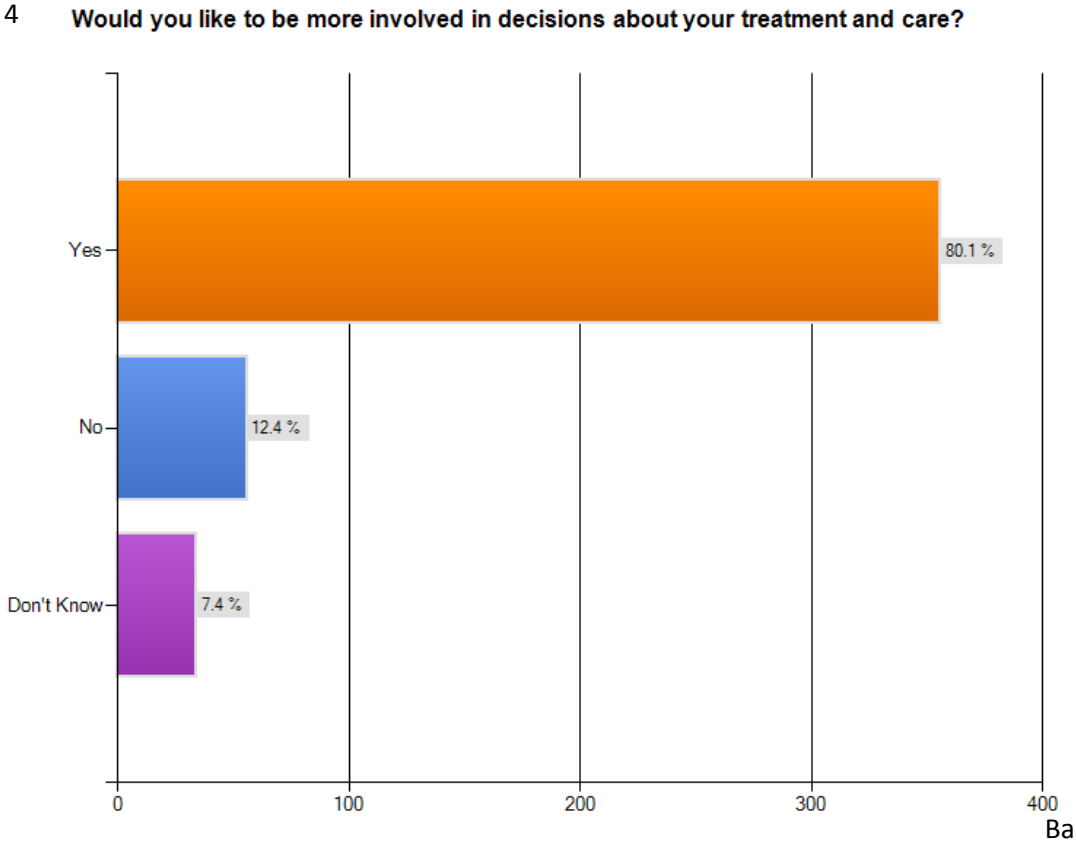
Fig. 4



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These results conform to what we hear from patients contacting our Helpline. One patient who contacted us told us, "As a carer for my elderly mother, sometimes information is seen to be all that is required instead of being able to discuss concerns and having more time with the care professional."

In the Patients Association report on information provision, just below a third of respondents (30.2%) felt they were involved to a great extent and 44% felt they were a little bit involved. The vast majority (84.6%) also said that they would like to be more involved in decisions about their care and 63.2% said that access to more information would help them be more involved in decisions about their care. With increasing importance rightly being placed on shared decision making and co-production GPs will need to look at ways to improve the provision of information.

The report also found that the majority (55%) of patients did not feel that they were receiving enough information from healthcare professionals.[26] When asked what areas they would like more information on around two thirds identified the following:

- Treatment choices and options
- Other services, e.g. physiotherapy
- Possible side effects of medicines
- The risks in relation to the benefits of treatment
- The effectiveness of treatment

There is certainly clear evidence that providing more information on treatments, including risks and benefits and general effectiveness not only in terms of patient experience, but also adherence to medical advice and clinical outcomes.[27, 28, 29]

It was particularly telling that when patients were asked where they got their information from, the most common answer was from websites with 66.3% of responses. GPs came second with 58.6%. These patients were also asked which source of information they found useful with 54% saying they found medical websites useful and GPs, coming second again, but this time with only 37.1% saying they found the information they provided useful.

It was heartening that in the *Information, What Information* report, published by the Patients Association 70.8% of patients said that they felt confident enough to enter into a conversation with their healthcare professionals and 78.6% felt confident enough to ask them questions.

However, many patients say that they are worried about raising concerns with their GP for fear of being reprimanded. One such patient that called the Helpline was Patient K. To book an

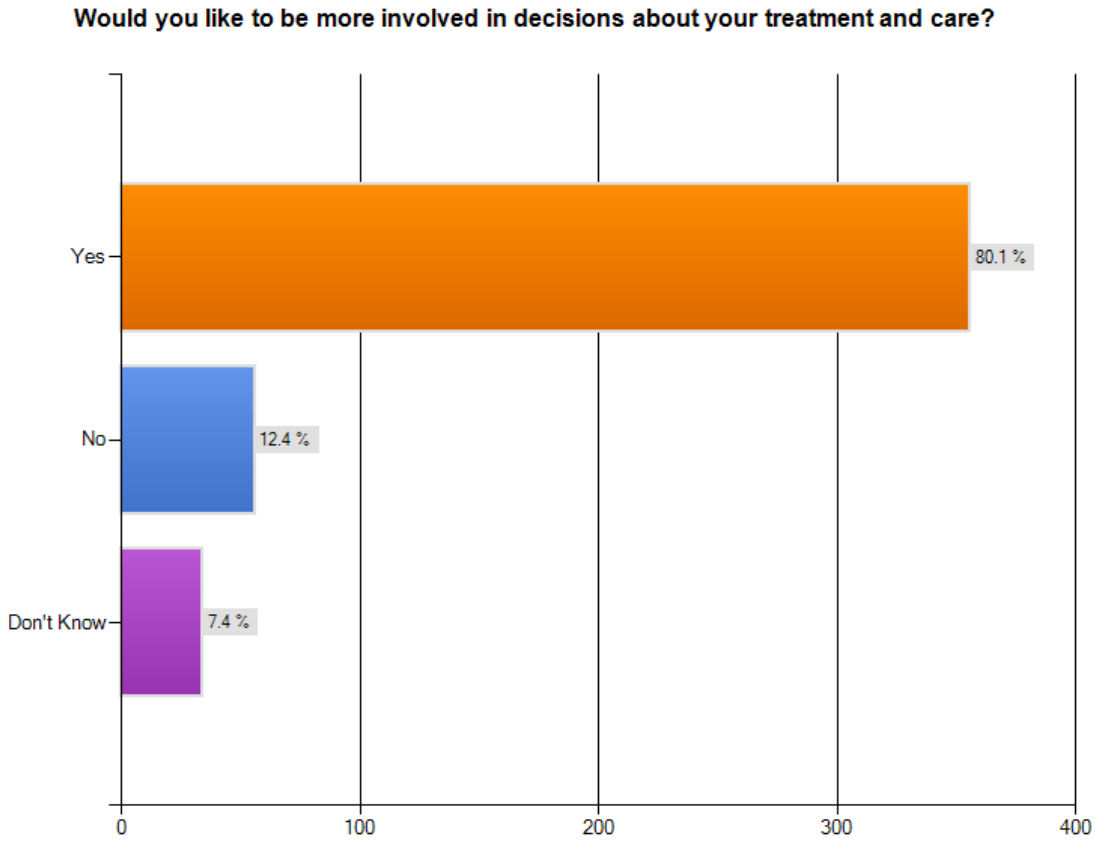
[26] Ibid 19
[27] Lin P, Campbell DG, Chaney EF, Liu CF, Heagerty P, Felker BL, Hedrick, SC (2005). 'The influence of patient preference on depression treatment in primary care' Annals of Behavioural Medicine, vol 30, no 2, pp 164–73.
[28] Bron MS, O'Neill J, Fogel I. (2006). Improving adherence to Sertraline treatment: the effectiveness of a patient education intervention. Prim Care Companion J Clin Psychiatry. 2006;8:285-290
[29] Jorm A, Griffiths, K, Christensen H, et al (2003). Providing information about the effectiveness of treatment options to depressed people in the community: a randomized controlled trial of effects on mental health literacy, help-seeking and symptoms. Psychological Medicine, 33, 1071 -1079

appointment with Patient K's GP he has to leave a message with the surgery and a GP will call him back to assess whether he needs an appointment or not.

Patient K feels that this is very distressing, especially for older patients. Patients are only allowed 3 minutes with their GP, which is not enough time for a patient to discuss their concerns and problems. Patient K is scared to raise his concerns as this may result in him, and his family, being removed from the GP's list.

In our survey, 69.8% of respondents had disagreed with their GP over some aspect of their treatment or care. Of those that had said they had disagreed in some way over with their GP, 84.3% had discussed it with their GP. When asked if their GP had taken their concerns seriously, just under half (48.2%) said that they had not (Fig. 5).

Fig.5



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These types of issue are most commonly reported by patients who contact our Helpline with regard to medicine changes. One patient who contacted the Helpline, Patient I, said she had been prescribed a particular drug for years and believes that this drug is working well. She is happy with her medication and would like it to continue. Her current GP has informed her that for financial reasons he will not prescribe the same drug anymore. He has prescribed her something different, which Patient I feels is not working in the same way and he is suffering from the side effects of this drug. Patient I's GP is not listening to her concerns and is refusing to prescribe any other drug.

Patients who come to their GP with worries and concerns should not have them dismissed in such a way. We know that many GPs are under pressure from Primary Care Trusts to make such cut backs, but they should never be at the expense of effective patient care.

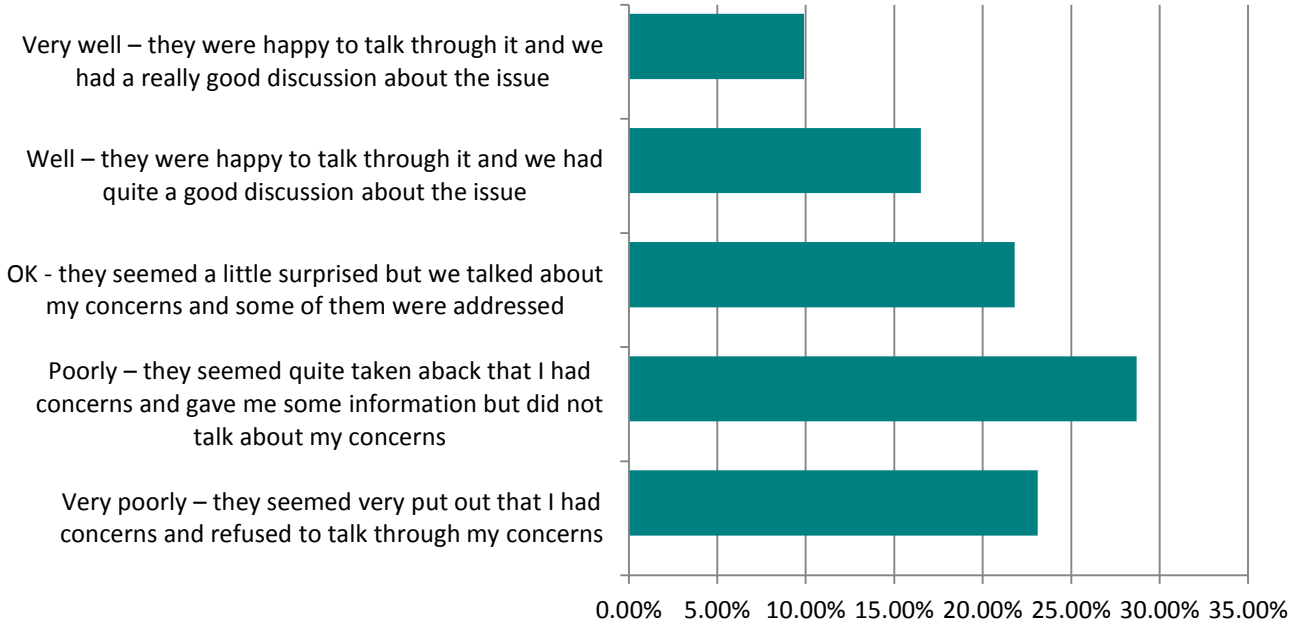
In addition, we asked patients how their GP had reacted when they raised their concerns with them (Fig. 6). Only 9.9% of patients said that their GP reacted very well and was happy to have a discussion with them about their concerns whereas nearly a quarter (23.1%) reacted very poorly and refused to talk about the patient's concerns.

One patient who contacted us told us, "As a chronic pain patient with a background in the health profession a G.P had seemingly been defensive at my attempts to make suggestions to help manage my condition. Rather than working together to help me to manage my condition, my attempts at making suggestions were viewed with suspicion. Even when visible scan results were finally able to confirm the extent of my injuries, there was still an unfavourable attitude."

It is worth noting, however, that there are some very good and conscientious GPs working today who take the time to talk to their patient. One patient told us "My GP and I have a good working relationship. He knows I only raise issues of concern and we discuss possible outcomes, treatments or care plans." It is vital that patients are involved fully in their care.

Fig. 6

How, in general did your GP react to your disagreement with his assessment?



Base: 303

In the Patients Association's 2010 report, *Public Attitudes to Pain,* it was found that many patients were nervous about discussing side effects with their GP. Only 61% of chronic pain sufferers had discussed concerns they had had about their medication with their GP. [30] When asked why they had

[30] Patients Association (2010) Public Attitudes to Pain

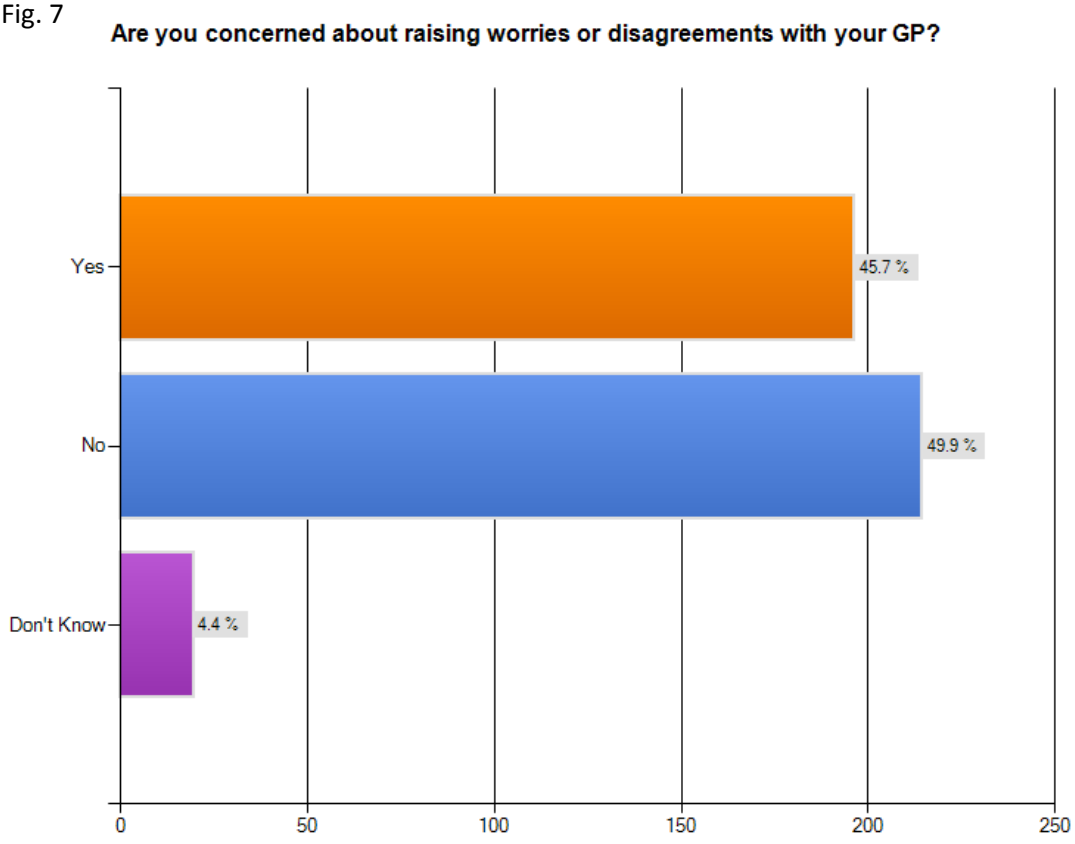
not discussed their concerns with their GP, many said that they were embarrassed or were concerned about giving the impression that the medicine was not needed. All healthcare professionals must ensure that they put patients at ease and give them ample opportunities to discuss their concerns, not just about potential side effects, but also other aspects of treatment.

Also in that report, patients were asked whether they took more or less than the stated dose of their medication. Fifteen per cent said that they took less than the stated dosage and a further 17% said they took more than the stated dosage. Amongst those who said that they took less than the stated dosages, 49% said that they were worried about side effects and 44% said that they were concerned about taking medication of any type. Over three quarters (76%) of those who took more than the stated dosage said that it improved their symptoms of pain and 64% said that it improved their quality of life.

Medicines adherence is an acknowledged problem in modern healthcare. The National Institute for Health and Clinical Excellence (NICE) has made it very clear in its guidance all healthcare professionals need to acknowledge that non adherence to medication advice is widespread and that it is up to healthcare professionals to have an "open and frank" discussion about medication with their patients.[31]

These results are further borne out by our survey which found that 45.7% of respondents were concerned about raisings their concerns or disagreeing with their GP's assessment (Fig. 7).

Fig. 7



Base: 429

[31] National Institute for Health and Clinical Excellence (2009). NICE Clinical Guidance 76: Medicines adherence: Involving patients in decisions about prescribed medicines and supported adherence.

We asked why patients were concerned about raising concerns or disagreements with their GP. Many were very concerned that it may affect their future treatment and care or that they may be told to leave. One said, “I am afraid of being struck off from the practice if I confront my GP,” and another said “I worry that I may waste my GP's time.”

We have also heard from patients who contacted our Helpline who are equally as concerned about raising such concerns.

Patients should not be afraid of reproach or embarrassment from healthcare professionals but should have the opportunity to have their concerns adequately addressed by their GP and to discuss their condition. Neither should they have concerns about being struck off or of wasting the GP’s time. Good communication skills are vital for this as is the quality of information provision.

Referrals

GPs act as the gatekeepers to other parts of the NHS for patients as it is impossible for patients to access many secondary care services without such a referral. In the UK there are an estimated 9 million referrals from GPs to elective secondary care every year.[32] This triggers an estimated national spend of £15 billion in the NHS.[33]

The King's Fund undertook research in 2010 on GP referrals which focused on the development of referral management centres.[34] They identified three key aspects of referrals:

- **Necessity**
  There is evidence that some GPs do refer patients inappropriately to secondary care when they could more properly be looked after in primary care by GPs.[35] There is also evidence that some patients who do need referral are not being referred in good time. [36]

- **Destination**
  In a world of increasing specialisation and complexity in healthcare, ensuring that patients are referred to the right place and to the right speciality is becoming increasingly important. There is some evidence, particularly in the field of musculoskeletal conditions, where patients have been referred inappropriately to the wrong specialism.[37]

- **Referral Process**
  This is in particular regard to the quality of referral letters. There have been concerns that the letters between some GPs and Consultants have been of a poor quality and may not include enough detail on why the patient has been referred, or indeed may be missing important clinical information.

Under the NHS Constitution, patients have the right to access NICE approved treatments that are clinically appropriate to their condition.[38] Yet, the Patients Association has increasingly heard in recent months that many patients are struggling to access treatments including hip replacements, knee operations and cataract operations. In 2011, the Patients Association published its first report on waiting times which found that there were 10,757 fewer surgical procedures carried out across 9 categories in 2010 than in 2009. This included 11% fewer Tonsillectomies, 6% fewer Knee replacements, 3% fewer Hip replacements and 51% fewer bariatric procedures. Our research also

[32] Hospital Episode Statistics (2008). Available at: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/HospitalEpisodeStatistics/index.htm (Accessed 21 September 2012)
[33] McKinsey et al. (2009) Department of Health. Achieving World Class Productivity in the NHS 2009/10–2013/14: Detailing the size of the opportunity.
[34] Imison C. Naylor C. The King's Fund. Referral Management: Lessons for Success. London. 2010
[35] Roland MO, Porter RW, Matthews JG, Redden JF, Simonds GW, Bewley B (1991). 'Improving care: a study of orthopaedic outpatient referrals'. British Medical Journal, vol 302, no 6785, pp 1124–8.
[36] Roderick P, Jones C et al (2002). 'Late referral for end-stage renal disease: a region-wide survey in the south west of England'. Nephrology, Dialysis, Transplantation, vol 17, no 7, pp 1252–9.
[37] Speed CA, Crisp AJ (2005). 'Referrals to hospital-based rheumatology and orthopaedic services: seeking direction'. Rheumatology, vol 44, no 4, pp 469–71.
[38] Department of Health (2012), The NHS Constitution for England - 2012

showed that patients have to wait longer for some procedures with some patients waiting 8 days longer for Hip and Knee replacements, and 6 days longer for Hysterectomies.

In the subsequent report in March 2012, *The Waiting Game,* we found that in total there were 18,628 fewer operations performed in 2011 compared to 2010. This accounts for a drop of 4.6% in the total number of operations carried out across the areas that we questioned. Of the 93 Trusts that responded with sufficient data, a drop in the number of surgical procedures was seen in seven of the eight categories.[39] Of those, almost 14,000 were cataract operations (see Fig. 8 for full results).

Fig. 8

Procedure	No. of procedures in 2010	No. of procedures in 2011	Difference between 2010 and 2011	Percentage difference
Hip	32,164	31,852	-312	-1%
Knee	36,846	36,437	-409	-1.1%
Hernia	51,852	50,166	-1,686	-3.3%
Tonsillectomy	26,080	24,613	-1,467	-5.6%
Adenoid	7,843	7,258	-585	-7.5%
Gallstone	32,377	33,397	+1,020	3.2%
Hysterectomy	23,573	23,011	-562	-2.4%
Cataract	189,998	175,731	-14,267	-7.5%

There have been accusations that Primary Care Trusts have been rationing care to patients by placing recognised, NICE approved treatments onto lists of Procedures of Limited Clinical Value (PLCV). In June, an investigation by GP Magazine suggested that more than 91% of Primary Care Trusts were limiting access to or rationing treatment by limiting GP referrals in 2012-13.[40] The Department of Health has reacted angrily to the introduction of these measures and said it would crack down on those Primary Care Trusts who were rationing care. A subsequent survey by GP Magazine found that over a third of Trusts were ignoring Government orders not to limit access to treatments on the basis of cost alone.[41] A further study by Imperial College London found that nearly half (47%) of Trusts had policies in place to limit access to cataract surgery and that 92% of 67 rationing policies ignored clinical guidance.[42] The Medical Director of the NHS, Professor Sir Bruce

[39] Patients Association (2012). The Waiting Game. Available at http://patients-association.com/Portals/0/Public/Files/Research%20Publications/The%20Waiting%20Game.pdf (accessed 25 September 2012)

[40] Moberly, T (2012) ' 90% of PCTs are now rationing care'. GP Magazine. 19 June 2012 [online]. Available at http://m.gponline.com/article/1136671/Exclusive-90-PCTs-rationing-care (Accessed 21 September 2012)

[41] Robinson S (2012) 'PCTs ignore DH ban on rationing care' GP Magazine 12 September 2012 [online]. Available at http://m.gponline.com/article/1148923/PCTs-ignore-DH-ban-rationing-care (accessed 21 September 2012)

[42] Coronini-Cronberg S, Lee H, Darzi A, Smith P. Imperial College London. (2012) Evaluation of clinical threshold policies for cataract surgery among English commissioners. Journal of Health Services Research & Policy. jhsrp.2012.012023;published ahead of print - 11 September 2012. Available at http://jhsrp.rsmjournals.com/content/early/2012/09/05/jhsrp.2012.012023.abstract (accessed online 21 September 2012)

Keogh, said that he would be writing to Trusts warning them that it was 'unacceptable' and 'unethical' to blanket ban treatment. [43]

Over the past two years, the Patients Association has increasingly heard that patients are being denied access to treatments, despite being NICE approved and having the right to access them under the NHS Constitution.[44] One patient who contacted us had been suffering from a hernia and was waiting for an operation. He was told that his case was not urgent and did not need immediate surgery. Patient H lived alone on a sheep farm. He told us that several times a day the hernia would pop out and he would need to use an ultrasound machine he kept for looking after his sheep to push the hernia back in. When he was finally allowed to have the surgery to fix the hernia, the surgeon told him that he was amazed that he had not been admitted as an emergency.

Many GPs, surgeons and other healthcare professionals have vocally and publically raised their concerns in relation to the rationing of care. Indeed, Dr Helena McKeown, resigned from her position as the Clinical Commissioning champion at the RCGP over the issue of rationing and concerns that through GP led commissioning, doctors were being asked to participate in the process.[45] A survey of doctors by Pulse Magazine found that 90% were reporting increased pressure to limit access to surgery and two thirds said that rationing was adversely affecting patient care.[46] A further three quarters warned that rationing was damaging the doctor-patient relationship.

As well as issues surrounding accessing elective surgery in particular, some patients have also had significant issues with the referral process. One patient who contacted the Patients Association Helpline said that she has been seriously ill and needed to be signed off sick from work. She had been to see her GP, who had promised her a referral. Weeks passed and she still had not a letter confirming an appointment with the consultant. It was a few weeks later, when she called the GP practice to find out that her referral letter had only gone out the previous day. This patient is very concerned that this delay in her referral may have lost her the benefits she could have claimed.

[43] Robinson S (2012). 'NHS chief warns PCTs over rationing'. GP Magazine 17 September 2012. Available at http://m.gponline.com/article/1150262/NHS-chief-warns-PCTs-rationing (accessed 21 September 2012)
[44] Ibid 38
[45] Lind, S (2012) 'RCGP commissioning champion resigns in protest at 'covert rationing' '. Pulse. 21 September 2012 [online]. Available at http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/14572480/rcgp-commissioning-champion-resigns-in-protest-at-covert-rationing (accessed 21 September 2012)
[46] Lind, S (2012) 'GPs face the flak as NHS rationing drive accelerates'. Pulse 19 September 2012 [online]. Available at http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/14614479/gps-face-the-flak-as-nhs-rationing-drive-accelerates (accessed 21 September 2012)

Deregistration

Patients can be deregistered from GP lists for legitimate reasons, for example where they have moved outside of the practice boundaries or where there has been unacceptable behaviour such as physical violence. However, there are increasing concerns about patients who are being removed from GP lists without a valid reason.

Both the RCGP and British Medical Association (BMA) have issued clear guidance on when it is acceptable to remove a patient from a list and the process the practice must undertake. The RCGP guidance emphasises the importance of the doctor-patient relationship and the necessity of communication in that relationship.[47] Patients should always be given a reason for removal from the list except where that would exacerbate unacceptable behaviour. It notes that the breakdown of the therapeutic relationship can be very upsetting and that doctors have a duty of care in a removal situation.

It also identifies the situations where deregistration is unacceptable. These include:

Clinical matters - patient choice
For example, where a patient:

- chooses a treatment regime of acknowledged validity, although it may be problematic for the practice (e.g. home confinement);
- refuses to participate in locally or nationally agreed screening programmes (e.g. cervical screening);
- refuses to participate, or allow their children to participate, in locally or nationally agreed preventive medicine programmes (e.g. immunisation);
- fails to comply with therapeutic or other health advice.

Critical questioning or complaints

- occasionally or persistently questions clinical techniques, safety measures or other practice matters;
- makes an informal or formal complaint.

Other circumstances

- the patient has an exacting or highly dependent condition or disability;
- the patient exhibits high levels of anxiety or demand about perceived serious symptoms;
- removal is based on any element of discrimination towards the patient.

The PCT should be informed of the proposed removal before it can take place except in the case of violent and threatening behaviour.

The guidance issued by the BMA states that the irretrievable breakdown of all or part of the patient-practice relationship is the normal reason for removal from GP lists though noting that violent or

[47] Royal College of General Practitioners (2004) Removal of Patients from GP Lists: Revised Guidance for College Members

threatening behaviour is completely unacceptable and warrants immediate removal. [48] However in those circumstances, the police must be informed of the patient's behaviour as well as the PCT.

The BMA guidance states that solely making a complaint is not enough for a patient to be removed from a list. It recognises that there is a public concern that patients are removed from a GP list simply for making a complaint. It recommends using the in house complaints system to discuss with patients incidents where the patient has acted inappropriately.

The guidance also states that it is unacceptable to remove patients for any of the following reason:

- Practices should never remove patients from their list because their treatment is too costly;
- Practices should never remove patients because they are suffering from a particular clinical condition;
- Practices should never remove patients on grounds of age;
- Practices should never remove patients on grounds of race, gender, social class, religion, sexual orientation or appearance.

Unlike the RCGP guidelines, the BMA guidelines also give advice on when a warning should be given to a patient that they are at risk of removal.

A patient must be warned that they are at risk of removal, together with an explanation of the reasons for this, within the period of 12 months before the date of the request to the Primary Care Organisation.

The GMC is in the process of finalising its guidance on this issue and it echoes what is said by the RCGP's and BMA's guidance. The GMC makes it clear that doctors must have a legitimate reason for removing patients from their lists.[49] All the guidance that is available states that the main reason for a patient to be deregistered is because of an irretrievable breakdown of part or all of the relationship between the GP and the patient.

No warning is required if:

- If the removal is on the grounds of change of address;
- The practice has reasonable grounds for believing that the issue of such a warning would be harmful to the physical or mental health of the patient; or
- The practice has reasonable grounds for believing that the issue of such a warning would put at risk the safety of members of the practice or those entitled to be on the practice premises.

Following removal the GP is only required to provide emergency treatment if it is deemed clinically necessary and patients are entitled to the continuation of treatment occurring more than once a week until patients are accepted by a new GP.

[48] British Medical Association (2005), General Practitioner Committee, Removal of Patients from GP Lists

[49] General Medical Council. "Ending a Professional Relationship with a Patient" (Due for publication December 2012 – draft available at http://www.gmc-uk.org/Draft_explanatory_guidance___Ending_your_professional_relationship_with_a_patient.pdf_48498022.pdf (accessed 24 September 2012)

Once patients have been removed patients can approach another practice to see if they will accept them as a patient. This process is the same as changing doctor for any other reason. If a patient has been removed from a GP list, they can be assigned to another practice but only if they have tried to register with at least three other practices without success.[50] However, refusal to allow a patient onto a GP practice list is at the discretion of the GP but cannot contravene standing discrimination statutory law.

While this guidance is quite clear, the Patients Association continues to hear about patients who have been deregistered from a GP list after making a complaint. Furthermore, there is evidence that in many cases, the guidance is not being followed. For example, in a study in Sheffield, removal rates showed significant variations in age and gender.[51] Young children, women in their twenties and both men and women in their eighties and nineties were removed from GP lists more than any other group. The ages and gender of those removed at a young age and in their twenties corresponds to target groups for childhood immunisation and cervical cytology. The increased number of elderly patients being removed could be due to so called "ghost patients", i.e. patients who have either died or moved away but remain on GP lists. However, it is worth noting that in two separate studies, the most common reasons for removal from GP lists were "unreasonable requests for medication" and "inappropriate use of services". Given that elderly patients will have greater healthcare needs, they will place more demands on the practice and the GP. This may account for the higher rates of removal. Indeed in June 2012 a practice run by the former head of the National Association or Primary Care, Dr Charles Alessi, was criticised for breaching its service contract following an investigation into why it had removed 48 elderly patients resident at a care home from its lists. The investigation found that they had been deregistered inappropriately "for financial reasons".[52]

The Parliamentary and Health Service Ombudsman's office has been a key player in highlighting the issue of inappropriate deregistration. In 1999, the then Ombudsman, Michael Buckley, began naming and shaming GPs who had refused to apologise for unjustifiably removing patients from their lists.[53] It was only after this that the BMA and RCGP issued their guidance. Twelve years later, the Parliamentary and Health Ombudsman, Ann Abraham, published her review of complaints handling in the NHS in 2010-11. Of the 2,581 complaints her office received about GPs, 21% were about inappropriate deregistrations, a rise of 6% from the previous year.[54] In one case sent to the Ombudsman, a patient had made a complaint and her entire family had been removed from the GP list. The ombudsman reiterated and emphasised that no patient should be removed from a GP list simply because of a complaint.

[50] NHS South East London (2012) Available at http://www.selondon.nhs.uk/directories/nhs_services/gp/gp_registration.php#removal (accessed 21 September 12)

[51] Munro J, Skinner J (1998), Unwelcome customers? The epidemiology of removal from General Practitioners' lists in Sheffield. Br J Gen Pract. 1998;48:1837–1839.

[52] Iacobucci, G. 'GP commissioning leader's practice deregistered elderly patients for 'financial reasons' '. Pulse 1 June 2012 [Online]. Available at http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/14062588/gp-commissioning-leader-s-practice-deregistered-elderly-patients-for-financial-reasons (Accessed 21 September 2012)

[53] 'Ombudsman to name unrepentant GPs'. BBC 17 June 1999 [Online]. Available at http://news.bbc.co.uk/1/hi/health/370876.stm (Accessed 21 September 2012)

[54] Parliamentary and Health Service Ombudsman (2011). The Ombudsman's review of complaint handling by the NHS in England 2010-11.

We have heard similar cases from patients and indeed, many others are concerned that if they disagree with their GP or make a complaint, they will be deregistered. One patient told us, "Access for appointments is appalling. But if I complain they can just knock me off the list - the whole family even. They don't have to explain why and they will be even less accountable when the PCT is gone."

Another, Patient D contacted our Helpline after having a problem with her GP, who she felt was rude and dismissive of her. She felt that the reception staff, were very pleasant, but did not make it easy for her to see her GP. She was concerned about her GP and that his abrupt nature made it difficult for her to speak to him about her concerns. She wanted to know if there was anything we could do to help or advise. We suggested that she raise her concerns with her practice manager. She was afraid that her GP would be unhappy with her if she did. I suggested she made a complaint to the Primary Care Trust if she felt uncomfortable speaking to the Practice Manager, which she also decided not to do as she did not want her GP or Practice to discover it was her making the complaint.

Patients should not be afraid of deregistration if they raise a concern or make a complaint, yet the practice continues. It is hard, however, at the moment to identify the specific reasons why patients have been removed from practice lists.

In our survey we asked if any respondents had been removed from their GP's lists. While the vast majority (93.1%) had not been removed from a GP list, 4.4% had. There are few sources of national information to indicate the number of patients removed from GP lists for reasons other than threats of violence or aggression or that distinguish between those patients removed because they have moved outside of a catchment area and those removed for other reasons. However, one study estimates the removal rate for patients from GP lists in England to be 4.3 per 10,000.[55]

[55] Munro J et al (2002). Patient de-registration from GP lists: and professional and patient perspectives Final report to the Department of Health. Medical Care Research Unit, University of Sheffield

Conclusions and Recommendations

Communication

Communication is vital to ensuring patients receive safe and effective care from any healthcare professional, yet it is clear from our research that there are significant issues still surrounding communication skills. While some GPs are able to give patients the support they need through effective communication, many others are failing to properly engage with patients.

Providing information alone is insufficient and GPs should be prepared to enter into an open and frank discussion with their patients as equals. If patients are concerned, they should answer those concerns with compassion and understanding. However, over a third (36.1%) of patients do not feel that their GP takes on board their concerns or what they are saying. Furthermore, patient ratings of their GP's communication skills represent a mixed result with over half rating their GP at least 7 out of 10 but with nearly two fifths (39.3%) rating their GP's communication skills 5 or below.

With the move to shared decision making, the provision of information is important, as our *Information, What Information?* report shows. However, so too is the ability of all healthcare professionals to engage with patients, address their concerns and help them come to an informed decision about their treatment and care. It is therefore deeply concerning that so many patients continue to say they want to be more involved in decisions about their care (80.1%) and that their GP reacted very poorly when their decision was questioned (23.1%).

The results of our survey, other studies and the complaints rate to the GMC on the issue of communication provide a strong base of evidence through which to argue for change.

We would recommend that the GMC includes the assessment of communication skills in its evaluation of doctors for the purposes of revalidation. There should be clear benchmarks of attainment for doctors set by the GMC and communication with doctors should be a separate and key part of recording patient experience of the work of a doctor.

Furthermore, we recommend that the Care Quality Commission (CQC) which is taking on responsibility for inspecting GP practices and ensuring good quality care at a primary care level use its inspections as an opportunity to identify GPs who are not communicating effectively with patients by engaging directly with patients during their inspections.

Referrals

Patients contacting the Patients Association Helpline are increasingly telling us that they are struggling to gain access to treatments. Indeed, the Patients Association's own research earlier this year has revealed the extent to which the number of operations taking place has fallen, particularly for cataract operations.

This is supported by external evidence showing that the rationing of treatment is becoming more prevalent, to the extent that the Department of Health is ordering Primary Care Trusts not conduct such "unethical" practices.

The Patients Association remain concerned with the many changes ahead as the structure of Primary Care fundamentally changes. What will happen when Primary Care Trusts transfer their powers and functions to CCGs, not only to the possibility of increased rationing, but also to the relationship between doctors and patients which could be put at serious risk.

We welcome the Department of Health's strong stance on this issue but despite its warnings, the practice continues. We will continue to raise the issue of rationing and the struggle of many patients to access routine, NICE approved care that they are entitled to under the NHS Constitution.

We further note that the NHS Commissioning Board will undertake responsibility for authorising and monitoring the operation of CCGs. We would recommend and call for a strong statement of intent from the NHS Commissioning Board on what it will do to prevent CCGs from participating in the same rationing schemes as Primary Care Trusts and explain how it will enforce that intent.

Deregistration

The Patients Association understands that under certain circumstances it may be necessary to remove a patient from a GP list due to violence or threatening behaviour. However, we are concerned that some patients are being removed illegitimately. We have heard from many patients contacting our Helpline that they have been removed without warning and without reason. The BMA guidance and the RCGP guidance make it very clear that this is not acceptable.

In particular, patients who have made a complaint are being removed for that reason alone which is inappropriate and has been condemned on several occasions by the Parliamentary and Health Service Ombudsman.

While the General Medical Council is in the process of issuing explanatory guidance on this issue, which clearly states that "persistent failure to fulfil this guidance could result in disciplinary procedures including erasure", it does not make clear what breakdown of the doctor-patient relationship means and leaves this to the discretion of the GPs themselves. We would recommend that the GMC makes it much clearer what this breakdown means and to clarify in general when deregistration is appropriate. In other words, to define what is not and cannot qualify as the breakdown of the relationship.

Furthermore, though guidance is important, some GPs are not following it. Those that are not following the guidance should be held accountable for not doing so. Action must be taken against those GPs and GP practices that persistently refuse to follow the guidance. The Department of Health should establish sanctions similar to those for mixed sex accommodation breaches for those GP practices and CCGs which are unable to give a reasonable or valid explanation for deregistering a patient.