despite the number referred remaining very low. The clinics seem to spend a lot of time reviewing children who should be in primary care (stable asthma for example). Here I hope commissioning can make changes.

- The breakdown in health visiting services, the removal of paediatric checks (after 6 weeks) from general practice all seem to have happened without any local decision making. Were our representatives involved in these changes?
- The model for best paediatric care in busy urban areas may be different from those of us in small towns 25 miles away from hospitals. But unless we put our own house in order and provide highly-skilled, prompt, comprehensive primary paediatric care, then it will be another nail in the coffin of 'general practice' if we lose paediatric care as part of our core role.

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REFERENCE

1. Saxena S, Francis N, Sharland M. Primary care of children: the unique role of GPs. *Br J Gen Pract* 2012; **62(600):** 340–341.

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Burnout and empathy in primary care

Thank you for your editorial on 'Burnout and empathy in primary care'.[1] These are crucial, but often neglected, factors in our day-to-day lives as GPs. However, I was surprised that there was no mention of resilience. There is a large body of literature that explores this as a protective characteristic when things get tough. One of the key underlying personal attributes that promotes resilience is a personal faith.[2] Many faiths also emphasise the need for compassion, and teach that compassion can be renewed through personal, spiritual activity. It seems to me that the potentially disparate characteristics of burnout and empathy can be linked through the medium of faith/spirituality. This is something that we are encouraged to address with patients,[3] is it about time that we encouraged its exploration for doctors?

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REFERENCES

1. Zenasni F, Boujut E, Woerner A, Sultan S. Burnout and empathy in primary care. *Br J Gen Pract* 2012: **62(600):** 346–347.
2. Masten AS, Reed MGJ. Resilience in development. In: Snyder CR, Lopez SJ (eds.). *Handbook of positive psychology.* New York, NY: Oxford University Press, 2002: 74–88.
3. Nicol J. The use of a workshop to encourage trainers to consider spiritual care. *Educ Prim Care* 2012; **23(2):** 131–133.

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Communication in the 21st century

As a GPST3 I often visit housebound patients who are unable to come to the surgery. Recently I received a request to visit a 40-year-old woman with a complex history of surgery for diverticular disease in 2010, including a Hartmann's procedure.

My consultation was on an unrelated matter, but during my assessment I asked whether her stoma was functioning well and if there were any plans for reversal, because it seemed from the notes to have been intended as a temporary measure. She was vague about any planned follow-up but said she would be keen to have the reversal. Throughout the consultation I had tried not to be distracted by the Facebook page given pride of place beside the sofa.

When I returned to the surgery it transpired that she had not attended the stoma clinic in 2010 and had then been discharged from follow-up. I arranged for her to be re-entered into the system and phoned her to keep her up to date with developments.

Sitting at home later that evening I couldn't help but ponder the situation. Although my patient was evidently enthusiastic as soon as I brought up the topic of stoma reversal, she hadn't picked up the phone to the surgeons or her GP in 2 years ... if only she could have found us on Facebook!

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Do English patients want continuity of care, and do they receive it?

Aboulghate and colleagues, in their analysis of GP Patient Survey data, conclude that most people value continuity but that practices need to flexibly balance it against speed of access.[1] Asking patients whether they prefer to see a particular GP invites responses that cannot reflect the complexity of their real decision-making.

We have previously reported a discrete choice experiment study of preferences for access to GPs that showed continuity to be a preference that is context-dependent and of variable importance.[2] Patients balance continuity of care against convenience of appointment time and speed of access, according to the reason for their consultation. Those with a long-standing illness value seeing the GP of their choice seven times as much as rapid access, while for those consulting with a child, rapid access is important. Overall, the extra time that patients in this study were willing to wait to see the doctor of their choice was less than 1 day.

Patients weigh up continuity of care as one of several attributes of the health care they require on a given occasion. The access we provide should reflect those values and its quality measured in more sophisticated ways.

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REFERENCES

1. Aboulghate A, Abel G, Elliott MN, *et al.* Do English patients want continuity of care, and do they receive it? *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X653624.
2. Rubin G, Bate A, George A, Shackley P, Hall N. Preferences for access to the GP: a discrete choice experiment. *Br J Gen Pract* 2006; **56(531):** 743–748.

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Confirming death in general practice

In 2008 the Academy of Medical Royal Colleges published a code of practice for

confirmation of death.[1]

There is some evidence to suggest that these guidelines are not followed.[2] We decided to find out whether GPs were aware of these guidelines and used them in clinical practice.

An e-mail was sent to 277 GPs in Dumfries and Galloway inviting them to participate in an online questionnaire regarding death confirmation. The questionnaire described a clinical scenario followed by questions on how death was confirmed. The survey also asked whether they were aware of the guidelines.

Eighty-six GPs responded: a response rate of 31%. Only 12 (14%) were aware of the guidelines.

The guidelines recommend assessing for the absence of a circulation for 5 minutes. Twenty-two (26%) responders said that they would assess for the absence of a circulation for 5 minutes or more and 42 (49%) would only assess for 1 minute.

Following 5 minutes of cardiorespiratory arrest, the guidelines recommend assessing the pupillary response to light, the corneal reflex, and the motor response to supra-orbital pressure. Eighty-three (97%) of responders said they would assess the pupils but only 14 (16%) checked the corneal reflex and 14 (16%) checked the response to supra-orbital pressure.

Prior to the publication of the 2008 guidelines, there was no formal guidance on how to confirm death following cardiorespiratory arrest. Practice varied from confirming death as soon as the heart stops to waiting 10 minutes or more.[1] Many textbooks do not describe how to confirm death[3] and *The Oxford Handbook of Clinical Medicine* published in 2010 describes the diagnosis of death in the following way: 'Apnoea with no pulse and no heart sounds and fixed pupils'.[4]

It is apparent that GPs in Dumfries and Galloway are not following these guidelines. Indeed the vast majority are unaware of this guidance. Does this matter? Diagnosis of death requires 'confirmation that there has been irreversible damage to the brain-stem, due to the length of time in which the circulation is absent'[1] and an assessment for only 1 minute is likely to be inadequate.

How could this be improved? These guidelines were distributed to medical directors of NHS trusts/boards for dissemination to relevant personnel. It is recognised that passive dissemination is ineffective and multifaceted approaches may be required to change practice.[5]

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REFERENCES

1. Academy of Medical Royal Colleges. *A code of practice for the diagnosis and confirmation of death.* London: Academy of Medical Royal Colleges, 2008.
2. Lowe G, Jefferson P. Confirming death: a survey of current practice. *Anaesthesia* 2010; **65(9):** 963–964.
3. Park GR. Death and its diagnosis by doctors. *Br J Anaesth* 2004; **92(5):** 625–628.
4. Longmore M, Wilkinson I, Davidson E, *et al. Oxford handbook of clinical medicine.* 8th edn. New York, NY: Oxford University Press, 2010.
5. Bero LA, Grilli R, Grimshaw JM, *et al.* Getting research findings into practice: closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. *BMJ* 1998; **317(7156):** 465–468.

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Recording concerns about child maltreatment

The recommended coding pathway, using a universal safeguarding code 'child is cause for concern' (with additional codes where indicated), as recommended by the RCGP Multisite Safeguarding Audit team,[1] has the potential to increase significantly the amount and consistency of safeguarding information recorded in primary care.

The universal code chosen would need to have a SNOMED CT®[2] equivalent or an application to have this term requested from the UK Terminology Centre. The team identified one of the barriers to recording safeguarding concerns is 'the disincentive to use permanent and potentially stigmatising codes that could be seen by patients and parents'. I would be interested to know if the team have, or plan to, conduct any research on the views of parents regarding coding and the universal term chosen. Although I would feel confident using the 'child is cause for concern' code where I would also code child protection plans and other significant family events such as domestic violence, I would hesitate to use this particular code for recording family risk factors where there is not a current concern about the parenting ability.

A single universal code would be ideal; if however, a suitable term could not be found to cover all situations, perhaps one term relating to actual child protection procedures and a second term to be used for recording 'risk' would increase recording. 'Family with young children' is a SNOMED CT which could be used in parents' notes to ensure any children in the household are kept in focus when the parent is seen.

GMC advice[3] states 'You must record your concerns, including minor ones, in the child's or young person's records (and in their parents' records …'. Pertinent family information including parental risk factors can be recorded in the child's records.[4] A coding pathway would need to clarify how to record this information so that it is easily seen, but not inadvertently shared, for example in a referral letter which has imported the child's problem list. An IT solution could be developed to avoid any risk of accidental disclosure and remove this potential barrier to recording.

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REFERENCES

1. Woodman Allister J, Rafi I, de Lusignan S, *et al.* A simple approach to improve recording of concerns about childmaltreatment in primary care records: developing a quality improvement intervention. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X652346.
2. NHS Connecting for Health. *SNOMED CT® The language of electronic health records.* TSO: London, 2010.
3. General Medical Council. *Protecting children and young people: the responsibilities of all doctors.* Manchester: GMC, 2012.
4. Royal College of General Practitioners, NSPCC. *Safeguarding children and young people: a toolkit for general practice.* London: RCGP/NSPCC, 2011.

DOI: 10.3399/bjgp12X654786