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## Consultation length: author response to Dr Brian Goss

Thank you for your response.<sup>1</sup> Consultation length was, as you suggest, observed rather than imposed. We were careful not to imply causality. As you rightly suggest, we cannot do so from observational data alone. We concluded that we found no correlational relationship between length of consultation and patient experience or patient satisfaction.<sup>2,3</sup> In our closing remarks in the full article, we suggest that:

*'Some consultations may be appropriately short, with both doctor's and patient's agenda effectively addressed, for example, where the doctor is dealing with a simple administrative issue or following up a problem with a patient whom they know well.'*<sup>4</sup>

This appears to be the conclusion you have also come to in your letter. We note in the full paper that a lack of evidence of an effect is not necessarily a lack of effect, and we do not want to suggest that consultation length should be made shorter or is not important for other areas of clinical practice.

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## Consultation length: author response to Dr Brigid Joughin

Thank you for your response.<sup>1</sup> We were also surprised at the lack of correlation between consultation and patient experience and patient satisfaction. In reference to your first point, the national GP-patient survey questionnaire communication items that we used in the study ask the patient specifically about whether they feel they had enough time in the consultation.<sup>2</sup> We conducted separate analyses to investigate whether there was any relationship between this item and consultation length, and found no evidence of an effect. There has been some interesting work conducted about patient perceptions of time in general practice by Ogden and colleagues.<sup>3</sup> She found that, overall, patients tended to underestimate the time spent with their doctor. She also measured the preferred time post-consultation and found that patients would have preferred longer with their GP. We agree it would be interesting to study patients' estimations of how much time they think they will need before the consultation.

With regards to your second point, we suspect you are correct in your hypothesis that there may be a stronger correlation. Unfortunately this is not something we measured as part of this study, although we did ask GPs to complete the same communication scale as patients and compared ratings of GPs and patients in the same consultation. We will be reporting these findings in a separate article.

Essentially we found that GPs tended to be more self-critical, compared with patients, which may give an indication of the direction of the hypothesis you suggest.

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## The Sore Throat Test and Treat Service: speed should not substitute science

We enjoyed the article<sup>1</sup> on new technologies in general practice and are excited by their potential; however, it is vitally important that these are appropriately researched. Recently, NHS England and Boots introduced point-of-care throat swab tests into Boots pharmacies<sup>2</sup> and following a small feasibility evaluation<sup>3</sup> (designed and funded by Boots) they now plan to roll this out nationally.

Pharmacy staff identified patients with a sore throat who had a history of fever and/or the absence of cough, and a trained pharmacist examined the tonsils for exudate and palpated for tender cervical lymphadenopathy. Three hundred and sixty-seven patients were recruited; 40% were positive for 3 of 4 of the CENTOR clinical scoring system (these patients were offered a throat swab test).<sup>3</sup> Patients were asked their hypothetical course of action had they not accessed the service, and data were

available on 60% of patients. From this, the number of GP consultations prevented and a reduction in antibiotic prescribing were estimated. The authors did not present any statistical data.<sup>3</sup>

A study such as this is at high risk of selection bias and is likely to overestimate any health service benefit. It omits the vital step of a control group in which the new service was not available, to calculate clinical effectiveness, cost-effectiveness, and impact. For example, CENTOR was developed and validated in patients attending A&E<sup>4</sup> and examined by clinicians. People self-presenting to a pharmacy are different from those seen in clinical settings; they are likely to be healthier, so fewer need antibiotics, limiting the potential for antibiotic reduction. Moreover, the skills of clinicians and pharmacists are likely to differ. It is therefore possible that this service may actually increase antibiotic usage.

As an NIHR Diagnostic Evidence Cooperative we are excited that NHS England is seeking innovative ways to improve patient experience and workload. However, we urge NHS England to consider the evidence (NICE does not recommend this test),<sup>5</sup> possible harms (including asymptomatic streptococcal carriage in low-risk populations),<sup>6</sup> and ethics (patients paid for this test and subsequent antibiotic treatment yet this obvious financial conflict of interest remains unaddressed).

For national-level changes, speed should not substitute science.

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## Clinical examination as a 'dark art'

Des Spence's article regarding clinical examination,<sup>1</sup> in my opinion, described a poorly considered viewpoint. In fact, in the same edition, a letter was published<sup>2</sup> that reflected my own view that clinical examination is paramount, especially in the isolated setting.

Working in the military environment, resources and investigative tests are limited. Purely on the basis of a history and clinical examination, I have to make a decision regarding whether my patient is fit to remain deployed in an austere environment or must return to the UK. Occasionally, this decision can impact on the ability of the military unit to carry out their tasking, which has impact beyond the individual patient. Without a firm grounding in clinical examination, I would not be