Letters

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Editor's choice

Keeping the electronic care record locked: lessons from history

Professors Wallace, Delaney, and Sullivan provide us with an unsettling glimpse into the arcane world of industrial scale medical science.[1] I am reminded of the European Enlightenment, the birth place of this very scientific approach to the mysteries of nature. Between 1750 and 1770 the French philosopher, Denis Diderot, devoted himself to the creation of the *Encyclopédie*, a monumental attempt to capture every branch of human knowledge. He believed that comprehensive knowledge would 'give the power to change men's common way of thinking'.[2] The project was mired in controversy largely through fears from the church and the aristocracy of giving the power of knowledge to the common people; as it turned out the fears were justified. Will this latest incarnation of Diderot's project liberate the people from our contemporary 'aristocracy', the elites of big business and politics? I fear not. Amid the ambition for comprehensive data and the explicit desire to boost the UK economy, the suffering individual is lost within the beguiling binary world of the 0 and the 1. This uniquely ill man, woman, or child is anonymised, electronically dismantled and reassembled in a form that suits BIG PHARMA. This is Diderot's progressive project turned on its head. Lets have nothing to do with it until we have learned how to appreciate the value of our uniqueness and of our shared destiny.

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Antibiotic overprescribing: who are the bad guys?

The July Journal includes many articles on trying to reduce antibiotic prescribing in respiratory infections.[1–5] May I bounce back a few obstacles?

Azithromycin to be taken three times a week? We have a growing cohort from secondary care of people with chronic airways disease, emphysema, and now also asthma, including children, who are put on this long term. Flares of chronic airways disease are poorly defined but antibiotics are considered good for this.

New syndromes like persistent wet cough in childhood seem to benefit from antibiotics. Ear, nose, and throat surgeons believe antibiotics work in sinus pain, despite vague NICE advice that seems to apply to primary care only.

There seems to be an epidemic of apparent urine infections diagnosed and treated with antibiotics in any ill older person in casualty. Any residential home resident where the staff can 'dip urine', and prescribing allied professionals are perhaps greater causes of current questionable prescribing.

Ill, hot children who attend hospital in our area always come out on antibiotics, usually co-amoxiclav.

All this makes it hard to stem the tide of antibiotic overuse. Add to this the failure of European or worldwide regulators to reduce pharmacy dispensing without prescription and it makes me wonder why we, as GPs, are seen as the bad guys.

The article on pharmacy advice also contrasts with the practice in southern Europe, where pharmacies appear to be pretty willing to sell antibiotics.

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The RTI clinical iceberg

The paper 'Expectations for consultations and antibiotics for respiratory tract infection in primary care; the RTI clinical iceberg'[1] has striking workload implications for GPs given that 58% of the UK population surveyed reported an RTI in the preceding 6 months, for which one in five had contacted their GP surgery. It is an important finding that over half of those patients contacting the GP expected antibiotics (53.1%).

However, exactly how big the problem of over-prescribing is cannot be determined from this study as the survey did not ask responders if they had been prescribed antibiotics for an RTI. Presenting data on expectations for antibiotic prescription for an RTI next to data on antibiotic prescription for any condition, as the 'clinical iceberg in RTI' (Figure 2 in the article), is perhaps misleading. Furthermore, although we are told that '97% of participants were prescribed an antibiotic when they asked for one', we are not told how many of the 74% who did not ask for antibiotics were prescribed them. Therefore it is not possible to attribute antibiotic prescription to patient demand.

Time pressures in primary care undoubtedly run counter to the need to minimise inappropriate antibiotic prescription as it takes longer to perform a full clinical and psychosocial evaluation of a patient, with education and safety-netting, than to issue an antibiotic. The paper overlooks the psychosocial drivers behind patients' attendance with minor RTIs, presumably because they did not emerge as themes in the qualitative interviews; that those of lower

socioeconomic status were more likely to have contacted their GP surgery than those of higher socioeconomic status hints at the possibility of life difficulties, coping skills, and educational attainment all influencing the need to consult in RTI.

On a more positive note, it is encouraging to learn that among the 14% of patients given a delayed prescription, a large minority (38%) did not collect them, confirming the usefulness of this strategy.

That 47% patients with RTIs consulted because their symptoms had not improved after several days confirms that patients often have unrealistic expectations about symptom or illness duration.[2] Patient education on this topic needs to be delivered effectively by GPs in their consultations, and in any public health campaign to reduce demand.

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In their NICE study on expectations for consultations and antibiotics for respiratory tract infection in primary care, the authors describe the point of view from the patients in an RTI clinical iceberg; the authors come to the conclusion that most who ask for antibiotics are prescribed them.[1]

In the triade patient–doctor–society, from the point of view of the society, as mentioned by the authors, more and more countries do national public campaigns to promote appropriate use of antibiotics in the community.

Otherwise, from the point of view of the doctor, one can also ask questions about the ICE (Ideas, Concerns, Expectations) of patients in general practice consultations, and their relation with medication prescribing. Now, do most patients expect antibiotics? Surely not.

In a study on ICE, an analysis of 350 new contacts showed that the expression/unveiling of expectations of patients (P = 0.009, OR = 2.0, 95% CI = 1.2 to 3.4) was associated with not prescribing new medication (dichotomised into the categories present/absent); in a subgroup analysis of respiratory complaints (n = 90), evidence was even found for fewer antibiotic prescriptions when two or three ICE components were present, compared to the group with no or only one ICE component, namely 6/36 versus 20/54 prescriptions of antibiotics (P = 0.056, OR = 0.34; 95% CI = 0.10 to 1.04).[2]

The conclusion of McNulty *et al*, may give the impression that patients especially expect antibiotics and this is not the truth. As many patients who contact their GP surgery expect advice and reassurance rather than antibiotics, there is an opportunity for GP practices to give more advice about how patients may relieve symptoms. Systematically disclosing the patients' real expectations and concerns could lead to less unnecessary use of antibiotics.

There remains an important link between the stages of the ICEberg, namely how the GP deals with request of patients for antibiotics.

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Family medicine in the emergency department, Jordan

Increasing demands on health services have resulted in a number of innovations in delivering care. In November 2005, a unique new care model was started in the emergency department (A&E) of Al-Bashir Hospital, the largest government hospital in Amman, Jordan. Family medicine physicians (specialists and residents) started working and are still working in newly added clinics to the A&E department, providing 24-hour primary care services to non-urgent patients; 'inappropriate attenders', on a non-appointment basis, with the aim of decreasing the pressure on the overburdened A&E department.[1]

In 2006 the total number of patients was 99 286 (272/day) in 2007, 102 127 (280/day), and in 2008 total 143 186 (392/day), a 40% increase. In 2009 the number of patients continued to rise, reaching a maximum of 649/day during the month of May. In October 2009 a nominal fee was re-established, that led to a dramatic decrease in the number of patients, falling to 8126 (271/day) in November. By 2010 the total number was 111 962 (307/day), a 37.2% reduction from 2009. In 2011 the total was 116 862 (320/day).[2]

Research from several countries support the new role of family medicine physicians in the A&E department. Boeke *et al*, in Amsterdam, the Netherlands, concluded that the new care method that combined the involvement of a GP in the A&E department and allocation of patients by triage to either the GP or the A&E physician, resulted in greater patient satisfaction and maintained the quality of care, with fewer additional examinations.'.[3]

Dale and his coworkers at King's College School of Medicine and Dentistry have been researching the demand for 'emergency' primary care since 1988. They concluded that employing GPs in the A&E departments to manage patients with primary care needs reduced rates of investigation, prescription, and referral when compared with hospital doctors.[1]

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