Letters

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Editor's choice

Hearing crackles: why all GPs should pass PACES

It was a pleasure to read Brettell's call to arms about the importance of clinical examination skills for GPs.[1] I am fortunate to work in a practice where three of us first passed the MRCP *en route* to entering our chosen profession as GPs. In an age of apparent demoralisation among GPs, the challenge and enjoyment of clinical diagnosis is a useful daily antidote. I still remember, as a GP trainee, debating with my trainer, months before his retirement, about whether a patient had a pleural effusion or consolidation. The chest X-ray proved him right, as he still reminds me in Christmas cards. Conversely, I also recall with satisfaction detecting the murmur of aortic regurgitation in my first months as a GP partner. My predecessor had passed the heart sounds as normal. The teddy bear from the hospital trolley, bought for me by the patient after her valve replacement, still cheers up grizzly toddlers in my consulting room. We teach third- and fifth-year medical students from Keele University during impressively long attachments in general practice, and I am often struck how cursory their examination techniques can be. Percussion of the chest, for example, seems to be regarded as alien to the general practice setting.

Perhaps the College should review its CSA scenarios and incorporate some that require demonstration of sound clinical examination skills.

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DOI: 10.3399/bjgp16X687673

Beyond the consultation room: GPs and physical activity

We read last month's editorial on promoting physical activity with pleasure, but feel the authors should have gone further.[1] If we discovered a drug that reduced the risk of cardiovascular disease, diabetes, and cancer by 20–50%, calls for more education and signposting would be seen as risible. Treating physical activity seriously is good for patients and has the potential to significantly reduce GP workload.

Lifestyle behaviours like smoking, drinking, eating too much, and moving too little cause around 40% of deaths in the UK,[2] yet we spend a relatively small amount of time combating these major drivers of disease with patients. In our surgeries we should ensure that we have bike stands, good public transport connections, standing desks, and adverts for local physical activity opportunities such as walking groups, exercise classes, and sports. We should support our staff in stopping smoking and maintaining a healthy weight by encouraging subsidised physical activity opportunities for NHS employees and access to cessation services.

Beyond the practice car park there are a myriad of ways that GPs can make a real difference to our communities by influencing the physical, social, and policy environments. We should be politically engaged: lobbying councils for green space, safe streets, cycle lanes, improved pavement surfaces, investment in public transport, accessible and affordable facilities for physical activity (including new free-to-access activities such as outdoor gyms), organised sports and community events, and accessible and affordable fruit and vegetables.

We have a clear mandate to engage in community-oriented health promotion,[3] but currently there are no incentives, no time, and no training. Virchow said, *'If medicine is to fulfill her great task, then she must enter the political and social life.'*[4] Promoting physical activity in our local communities demands this approach, and has the potential to reduce workload, prevent disease, and ultimately save lives.

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DOI: 10.3399/bjgp16X687685

Antibiotic eye drops for conjunctivitis in infants at nursery

The pressure to prescribe also exists in community pharmacy. In Scotland the minor ailments scheme, which is available to children registered to a GP practice, provides the opportunity for community pharmacies to supply antibiotic eye drops directly to parents at no cost to them. A patient group direction for chloramphenicol eye drops also allows this supply outwith the product licensing for the over-the-counter version of chloramphenicol eye drops; allowing the supply of generic chloramphenicol eye drops to infants.

While locuming on Saturdays I have often supplied chloramphenicol eye drops to parents because of nursery policies that allow infants to attend nursery if they are being 'treated'.[1] I do this knowing that the underlying cause of the infection is likely to be viral, which I feel uneasy about as it goes against my pledge to good antibiotic stewardship.

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DOI: 10.3399/bjgp16X687697

Prevention of hospital-acquired thrombosis

Perhaps the *BJGP* should have a moratorium on papers which state that, 'GPs are ideally placed to …'? Yes, I'm sure you can find someone to say we're great at everything in medicine and beyond. But that doesn't mean it's our job or that we are actually the best people for it.

I'm pleased to report that in our area there is no uncertainty on this issue: hospital staff, who are actually ideally placed to assess and treat hospital-acquired thrombosis, do it.[1] Surprisingly, it has never crossed my mind that we may want to take this work off them, as they have detailed knowledge of the surgery or other factors that have occurred during admission, rather than the brief highlights on a discharge letter, and they have pre-surgical assessment clinics for elective admissions already in place where this can be addressed without any need for GPs to take on yet more workload. I imagine that they also have detailed knowledge of the guidelines, as they use them every day. Sure, I'll highlight any particular risks if I refer someone, but given that I may not see them again from referral for an outpatient consultation (at which point surgery is not definite in most cases) until they come out of hospital months later at the end of an 18-week routine wait, I'm not sure that discussion of DVT risk for an op that may not happen at that point is necessary.

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DOI: 10.3399/bjgp16X687709

Improving access to primary care: can online communities contribute?

Roger Jones's editorial[1] described primary care in the context of accessibility, effectiveness, and care that is provided personally, and concluded that creative solutions are needed. More than 15 million people in England have a long-term condition or disability for which there is no cure, and these people account for at least 50% of all GP appointments.[2] Peer support is a self-management activity[3] with the potential to improve self-care while reducing demand for primary care appointments. Work on an online community of patients with stroke revealed that up to 95% of information and support requests were answered on an individual basis.[4] Responses received by peers were accurate and appropriate. At a time when GP surgeries are working at and beyond capacity, and patients are finding it difficult to obtain appointments, these online forums can provide a way for stroke survivors and their carers to receive helpful advice and support. As the NHS has been challenged to develop and benefit from digital health, primary care research should explore online patients' communities as potential self-management interventions. Such interventions could take up part of the service demand for information and indirectly improve access to primary care.

The use of online peer support within the NHS will be driven by providing research evidence that it is a cost-effective way of improving patient health and welfare. Outstanding questions to be answered include:

- How do effective online patients' communities form and maintain over time?
- What are suitable outcome measures for measuring effectiveness and cost-effectiveness of online peer-to-peer self-management?
- What part of healthcare demand can be safely dealt with by online patients' communities?
- How can online patients' communities be effectively policed to protect individuals from online risks?

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