# Letters

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## Editor's choice

## Our role in addressing inequalities

It was fantastic to have an issue devoted to socioeconomic health inequalities; one of the defining issues of our time.[1]

As doctors we have an important role to play in *'... improving and protecting the nation's health and wellbeing, and improving the health of the poorest fastest'*.[2] However, in general practice most of our interventions are aimed at the individual level. Compared with population-level interventions like taxing alcohol, banning trans fats from foods, enforcing smoke-free public places, and promoting healthy urban design, individual-level interventions can actually exacerbate socioeconomic inequalities.

Julian Tudor Hart's inverse care law states that services are used most by those who need them least.[3] Aside from health service utilisation, all interventions that require health literacy or healthy choices tend to widen inequalities. Living in conditions of deprivation imposes a 'poverty tax' that impedes people's ability to align their short-term actions with their long-term interests.

Although it is important that we continue to quantify health inequalities, we need to be careful not to inadvertently promote them by restricting our activities to those that disproportionately benefit the well-off.

GPs have an important role to play in addressing local-level social determinants of health through commissioning, advocacy, and service provision. We look forward to reading more articles on inequalities where the focus is on addressing them at a population level in our daily practice.

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2. UCL Institute of Health Equity. *Fair Society Healthy Lives (The Marmot Review).* 2010. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review (accessed 10 Feb 2017).
3. Tudor Hart J. The inverse care law. *Lancet* 1971; **1(7696):** 405–412.

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## The vanishing skill of watchful waiting

I was glad to read Professor Ogden's thoughtful 'Out of Hours' on 'The vanishing skill of watchful waiting'.[1] Clearly, as the Preacher says (Ecclesiastes 3:1) there is a season for everything; a time to act immediately and a time to 'wait a wee while'. The skill in both the art and science of medicine is in knowing when the one or the other is the more appropriate and safer pathway; not at all an easy decision but surely as important in medical education as the sequencing of genes and the managing of budgets.

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### REFERENCE

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## Consultation length

Consultation length in general practice has long been seriously under-researched given its central importance. The key issue is serious, as Orton and colleagues show that longer consultations are significantly more patient centred and beneficial for patients[1] whereas Elmore and colleagues find no benefit in terms of patient experience from longer consultations.[2]

Both studies have the advantage of studying substantial numbers of precisely timed consultations, 440 in Elmore and colleagues and 842 in Orton and colleagues. The latter applied an internationally validated instrument for assessing patient-centredness, whereas Elmore and colleagues had the advantage of obtaining patient responses directly.

A weakness in both studies is that they had relatively few consultations lasting 15 minutes or more; only 74 (16.8%) in Elmore and colleagues and 50 (6.1%) in Orton and colleagues. Benefit for patients is likely to be optimised when patients know that they will receive at least 15 minutes and then on average do so, which applied in neither study.

Elmore and colleagues studied practices *'... below the 25th percentile for mean communication score in the 2009–2010 survey, adjusted for patient case mix'*. This group selected for relatively poor communicators probably lacked the consulting skills to give patients a good experience, even with more time. This important limitation was clearly stated in the full version, but did not appear in the two-page printed summary of the article.

We do not believe that results from GPs selected on the grounds of being poor communicators can be generalised. An absence of evidence does not indicate evidence of absence.

Meanwhile, decisions must be taken by managing partners about how long on average patients' appointments should be. We confirm that in our two very different research general practices patients receive on average 15 minutes or more (mean 16.1 minutes in St Leonard's). Further research on consultation length is urgently needed.

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