Life & Times

RCGP Research Paper of the Year 2016:

how the winning papers are so relevant to clinical practice

The Research Paper of the Year (RPY), awarded by the Royal College of General Practitioners (RCGP), gives recognition to an individual or group of researchers who have undertaken and published an exceptional piece of research relating to general practice or primary care. The award spans six clinical categories, with one overall winner.

We had an excellent response to our call for papers from 2016, with 87 submissions, and I am indebted to the RCGP's Clinical Innovation and Research Centre (CIRC) for the support provided for the judging process. The winners of all six categories are decided by sub-panels, and the overall winner decided during a teleconference of sub-panel leads. Again, thanks are due to the GPs who give of their time judging all the entries. The key to this award is 'relevance to clinical practice'. We asked the winners of each category to describe the clinical implications of their work. Here, I consider how the winning papers are relevant to patients I saw in a recent surgery.

THE PAPERS AND THEIR CLINICAL RELEVANCE

Mr A, aged 72 years, is someone who I have seen on a fairly regular basis for the past 16 years. I think of him as having recurrent depression. He remains on citalopram, and we often increase the dose from his maintenance dose of 20 mg daily to 30 mg in the autumn. I am aware that the evidence base for this change is limited. The overall winning paper, led by Wiles,[1] suggests that I might think of Mr A as having treatment-resistant depression and refer him for assessment for suitability for psychological therapies. Dr David Kessler says:

'This study followed the same patients for an average of nearly 4 years and found robust evidence for the long-term clinical and cost-effectiveness of high-intensity CBT [cognitive behavioural therapy]. *This highlights the need for NHS investment in one-to-one CBT with an accredited therapist for depressed patients in community settings.'*

I intend to discuss possible referral with Mr A at his next appointment with me.

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Sarah P attends for a repeat of her oral contraception. She obviously hasn't been diverted by the receptionists to see the practice nurse, and I am thankful that a fairly short, straightforward appointment will help me catch up. I note that Sarah is due for a cervical smear, and I remind her of this. *'What's the point?'* she says. I think about Willie Hamilton's comment on the winning paper in the 'cancer' category,[2] published in the *British Journal of General Practice*:

'Wouldn't you like a simple test for women under 30 with gynaecological symptoms that just might be cervical cancer — but almost certainly isn't? Would you like high sensitivity (so few cancers are missed) and a high chance that a positive result is cancer? And a test you can perform in your surgery? There is one: cervical cytology! The sensitivity of moderate dyskaryosis is over 90% and the chance of cancer at least 10%. Cytology has a new role: testing as well as screening.'

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Mrs P sits down and says she has been asked to come in for a 'medication review'. She is 85 and we prescribe nine different drugs, including aspirin. I reflect on the paper by Dreischulte[3] and wonder if she has been reviewed by our practice pharmacist. Mrs P is just the sort of patient we had in mind when we recruited our pharmacist. We are not sure that we will be able to demonstrate a reduction in hospital admissions by our intervention in practice, nor whether we will be able to continue to fund our pharmacist. This paper adds to the evidence base that our Clinical Commissioning Group (CCG) should be aware of. Professor Guthrie reflects:

'The DQIP trial adds to the evidence that high-risk prescribing in general practice can be significantly reduced by briefly reviewing patients at particular risk, and shows for the first time that patient harm in the form of emergency hospital admissions with drug adverse effects is reduced. Practices and CCGs should consider which types of high-risk prescribing are a priority for them, and identify and review patients at particular risk'.

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Mr J says he was sent by the practice nurse, following spirometry that suggests he has chronic obstructive pulmonary disease (COPD). He has smoked for 40 years and doesn't feel he can stop. I wonder if we should have made the diagnosis earlier. Jordan's paper[4] suggests that a targeted case-finding approach for COPD should be considered. I will bring this up at the practice meeting. Professor David Fitzmaurice comments:

'This study has demonstrated conclusively that actively looking for patients with COPD, utilising a screening questionnaire and confirmatory spirometry in primary care, can improve the case detection rate by more than seven times compared to routine care. Whilst it remains too early to recommend a formal screening programme, it is encouraging to know that we can increase case-finding with relatively simple and evidence-based pathways within primary care. The next challenge is to identify therapies which can genuinely improve outcomes in those detected earlier.'

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The trainee advanced nurse practitioner (ANP) messages me about a triage call she has made, a 5-year-old girl whose parents think she has *'another UTI'*. Hay's paper[5] stresses the importance of dipstick testing. I reply to the ANP that her suggested investigation and management plan are fine, thank you.

Professor Hay says of the DUTY study:

'These results form the basis of a two-step clinical rule to help GPs and nurses to identify the children from whom a urine sample should be obtained (using symptoms and signs); and which children to treat with antibiotics (taking account of dipstick results).'

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Mrs R attends, worried about a new spot on her face. She has a history of basal cell carcinoma. I examined the lesion and advised her that I think referral for excision is needed. I note that she has been on prednisolone for polymyalgia rheumatica (PMR) and her ESR has been monitored and dose reduced, very efficiently, by the practice nurse, but Mrs R hasn't been reviewed for 6 months. I think of Muller's paper[6] and recall that people in their cohort study complained of pain and stiffness, as well as fatigue and poor sleep. *'How are your muscles feeling?'* I ask. Mrs R grimaces and says that, since her prednisolone was reduced to 7.5 mg daily, she has been feeling *'really rough'*.

We agree to increase her prednisolone and I message the practice nurse to explain why I have done this. I emphasise the need for Mrs R to return to one of us in a couple of weeks, advising why I would like to monitor her symptoms, not just her ESR.

Dr Muller reminds us that:

'Despite being managed almost exclusively in general practice, existing research has been conducted in secondary care with patients with atypical disease activity. This study is the first to investigate PMR in the setting where it is diagnosed and managed and helps us understand the severity of symptoms and the impact on patients.'

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What a privilege it is to chair the RCGP RPY, and how relevant is the research that is conducted so well by the teams who have won our awards. I look forward to next year's call for papers and would encourage all GPs to look out for publications that have impacted on their clinical practice to think about nominating those papers for this award.

Carolyn Chew-Graham,
GP Principal, Manchester. Professor of General Practice Research, Keele University, Keele, Staffordshire.

E-mail: c.a.chew-graham@keele.ac.uk

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The Future of the Professions: How Technology Will Transform the Work of Human Experts
Richard Susskind and Daniel Susskind
Oxford University Press, 2015, HB, 364pp, £18.99, 978-0198713395

EXISTENTIAL ANGST IN A DIGITAL AGE

I think it is fair to say that the current state of general practice may leave a few of us gazing wistfully into our cornflakes, mulling over the future of our profession. For those of us without enough existential angst about where we are headed, then *The Future of the Professions* provides plenty more ammunition with a smattering of food for thought. Early in the book the co-authors unashamedly put doctors, lawyers, teachers, accountants, and other 'human experts' directly in their 'cross-hairs'. This 364-page volume predicts not only radical change in the work professionals do but also even portents their destruction, underpinned by details of how the work of professionals will largely be performed by increasingly intelligent computers. The publishers claim this book *'Urges readers to rethink the way that expertise is shared in society'* and *'Builds on 30 years of research and practical work.'*[1]

The first section of the book in particular makes for uncomfortable reading as the various shortcomings of professional groups are laid bare in some detail. I think the most prominent of these is the accusation that doctors (and others) run a closed shop on knowledge and expertise that is fiercely guarded by elitist institutions.

As the book progresses from problems to solutions it becomes an easier read and signposts to cross-disciplinary innovations that had me reaching for the laptop to explore further. It was a revelation for me to discover that various top universities now offer free online courses called Massive Open Online Courses (MOOCs). Just flicking through the selection from Harvard had me planning new tangents for my next appraisal year and gave me some new perspectives on GP training.

That said, the sections on medical 'advances' did not lead me towards a better understanding of how we might use technology in a way that allows us to help patients to have better deaths, for example. Or, furthermore, how those golden subtleties of communication in face-to-face consultations can be preserved through electronic alternatives.

Perhaps most powerfully the mere fact that I was reading the text on something as old-fashioned as paper failed to convince me to shred my stethoscope and head for the Apple Store.

William Mackintosh,
GP, Coach and Horses Surgery, Carmarthenshire. Chair, Royal College of General Practitioners, South West Wales Faculty, Wales.

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ADDRESS FOR CORRESPONDENCE
William Mackintosh
Coach and Horses Surgery, Carmarthenshire, SA33 4AA, UK.
E-mail: will_mackintosh@yahoo.co.uk

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