Letters

All letters are subject to editing and may be shortened. General letters can be sent to **bjgpdisc@rcgp.org.uk** (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication.
For submission instructions visit: **http://www.bjgp.org/letters**

Editor's choice

I enjoyed the article about how to combat urgent care pressures by improving collaboration between primary and secondary care physicians.

You state that educational days for GPs to spend time in the acute admission unit have been of mutual benefit. I am wondering whether you have considered a similar educational day for acute consultants to spend time in general practice. Perhaps this would provide insight into the reality of community care, promote a more positive relationship and encourage shared ideas about how cooperation can be improved.

The September 2013 Future Hospital Commission report from the Royal College of Physicians proposes improved integration of acute, general, internal, and community doctors. In time this should mean that community placements become a key part of core medical and medical registrar training; certainly acute medical placements already feature in the majority of general practice training programmes. Broad-based training programmes have also been implemented in several deaneries aiming to provide 'specialist generalist' doctors. Hopefully these attempts to gain a common understanding of our specialties will help to provide a more effective service to our patients.

Helen R Pidduck,
GPST1, Bristol GP Training Programme.
E-mail: hrpl@doctors.org.uk

REFERENCE

1. Roseveare C. Acute medicine and general practice: a key interface in managing emergency care pressures. *Br J Gen Pract* 2014; **64:** 122–123.

DOI:10.3399/bjgp14X679570

Five cards

The authors of the interesting Debate & Analysis article[1] mention that the application of five cards might show — verbally and non- verbally — that the doctor has recognised and understands what he has heard: when the three patient's cards of Ideas, Concerns, and Expectations (ICE) have been played, the doctor may have a better understanding of the patient's illness experience; and the two other Receipt and Summary cards seem to be a response as a receipt in confirmation.

Although the application of the aforementioned 'cards' seems justified, and most of us have the impression that the ICE acronym works,[2] until now there is a scarcity of studies on ICE: there are no (efficacy) randomised trials on ICE and no patient satisfaction studies on this acronym. As far as we know there is only one cross-sectional study with students in educational training which showed that the mean number of ICE components per doctor and per contact was 1.54 (SD 0.54); one, two, or three of the ICE components were expressed in 38.5%, 24.4%, and 20.1% of contacts, respectively. On the other hand, in 22% (77 out of 350) of the new contact reasons, no ICE was voiced, and the GPs operated without knowing this information about the patients.[3]

In our contact with students and their video consultations of patients, we perceive some recurring facts:

- Students are 'conditioned' and tempted to concentrate on the detail of the symptoms instead of what the presenting problem means for the patient with its current and future implications. They find it sometimes difficult to explore the ICE components and to clarify and play all (unexpressed) ICE cards; because expectations are often difficult to explore for students, we suggest alternatives for example: 'Mr X, you expect an X-ray or you want medication now?'; or 'What do you prefer: a painkiller or had you thought about a blood analysis first?'. Indeed, there is the need to develop a personal repertoire of questions and answers which sound fresh and 'tailored' to the particular patient, rather than formulaic and unnatural phrases about ICE.
- It is a learning process to structure the consultation and to learn the interplay between the five cards and to give clear and unambiguous receipts. For example, it is often easier to nod or to mumble agreement rather than (dare) to show real empathy and interest in the story of the patient.

The five cards seem a simple guide for the experienced practitioner but are they for the beginning practitioner? This is not a criticism of the article but a request for more evidence on ICE and more evidence on the reciprocal relationship of the five cards and in that way we congratulate the authors for their refreshing debate and analysis.

Jan Matthys,
Lecturer, University of Ghent, Department of General Practice, Belgium.
E-mail: jan.matthys@ugent.be

REFERENCES

1. Larsen JH, Neighbour R. Five cards: a simple guide to beginning the consultation. *Br J Gen Pract* 2014; **64(620):** 150–151.
2. Olde Hartman TC, van Rijswijk E, van Dulmen S, *et al.* How patients and family physicians communicate about persistent medically unexplained symptoms. A qualitative study of video-recorded consultations. *Patient Educ Couns* 2013; **90(3):** 354–360.
3. Matthys J, Elwyn G, Van Nuland M, *et al.* Patients' ideas, concerns, and expectations (ICE) in general practice: impact on prescribing. *Br J Gen Pract* 2009; **59:** 29–36.

DOI: 10.3399/bjgp14X679589

Author's response

Thank you for your challenging letter and for the opportunity for us to comment.[1]

Having looked at video consultations from both experienced doctors and medical students over the past 25 years I have seen the recurring pattern of interrupting the patient's story due to perceived time pressure, powerlessness, and the urge to test hypotheses. It turns out to be so difficult for the doctor to explore the world of the patient before entering the familiar world of medicine.[2]

To understand why the patient is here and to feel a natural empathy, I need to know his ICE. The two cards, Receipt and Summary are effective tools for introducing the ICE questions and not asking for symptoms and test hypotheses. Then the doctor can stay in the patient's part until the patient has finished his prepared story and is ready to listen. Rather than looking at ICE and the cards as something we have to do for the