Letters

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Editor's choice

What advice should we give to patients about *their* consultation?

In 'Tips to help your GP', the focus is on helping the patient to help the GP.[1] Although this is obviously important, the patient is the person who should come first. Being a GP must be incredibly stressful. Undoubtedly there are things that patients do that make the job harder. But patients are often nervous, may have had bad experiences, and may be very poorly. I think it is important to be as positive and helpful as possible, rather than giving them reasons to feel worse.

Your poster has no introduction and seems critical towards the patient reading it. Parts feel very patronising, such as the points that focus on 'behaviour and attitude' in the consultation, telling people to cover their mouths when coughing, to 'dress appropriately', and to make sure they have washed. Many patients would love your suggestion about continuity of care, but then they would often be unable to see someone for several weeks. Booking with the 'correct professional' is ideal but it is not always obvious who this is.

It would be more helpful and positive to have 'Tips to help your GP help you' and to help the patient ask appropriate questions such as those suggested here: https://www.nhs.uk/nhsengland/aboutnhsservices/doctors/pages/questions-to-ask-the-doctor.aspx.

I wonder if you asked patients about what would help them during a consultation? Health care should be a partnership, with GPs who are the experts by training, working together with patients, who are the experts by experience.

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Scholarship-based medicine

Few *BJGP* readers will disagree with Professor Reeve that *'[w]e need whole-person, generalist medicine'*.[1] But I feel that Reeve uses an overly narrow conception of evidence-based medicine (EBM) to justify throwing the baby out with the bathwater. By omitting to reference the growing literature that critiques EBM, this article sets up a straw man, ignoring the well-established move to focus on evidence-based practice. This move challenges the old 'knowledge pipeline' model, in which clinicians simply received 'proven facts' and used them, and patients relied on clinicians to hand over these facts. Instead, we need to understand the way both clinicians and patients construct knowledge and use it in making decisions together.

I agree with Reeve that this understanding requires a more nuanced model than the version of EBM she portrays. But rather than replacing this old (and increasingly discredited) model with a new one that emphasises the distinction between 'specialist' and 'generalist' practice, I suggest it will be more helpful to build on Greenhalgh *et al*'s call for a new 'real EBM',[2] highlighting the central challenge that all clinicians face: how to use probabilistic information about a population to shape decisions about one individual. Like generalists, specialists should use this information within a holistic, person-centred approach that requires wisdom as well as 'science', although we all struggle to achieve this. As a GP, I cannot achieve it in 10 minutes, however much I 're-prioritise'. Before trying to devise a way to evaluate my *'capacity to deliver person-centred care'*, why not fund me to offer patients a bit more time and continuity, and then check that I am providing it?

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Scholarship-based medicine and retirement of EBM

Reeve's article does not address several issues, which simultaneously make the approach under-ambitious and have divisive, probably unintended, consequences.[1]

First, are there specialists and generalists? Many 'specialists' practise in 'generalist' mode within their discipline, and GPs with a special interest contribute to secondary care.[2] The division suggested by Reeve would not incorporate these colleagues who would presumably utilise different philosophical models in different roles. It seems unlikely that these are the only models to answer clinical questions and that there is no spectrum between these approaches. For example, psychiatrists take a biopsychosocial approach to formulating a patient's diagnosis and management.[3]

Scholarship-based medicine does not recognise that different approaches are needed at different times. The generalist will likely follow protocol in an emergency resuscitation situation; specialists may need to make a diagnostic decision, then consider the appropriateness of major life-changing treatment incorporating a wide range of factors.

However, our major concern is the implicit criticism that specialists do not consider the whole patient. This type of 'bashing' has been the subject of academic debate and widespread campaigns by royal colleges with the aim of improving recruitment.[4] Such division is unhelpful to all.

The Chief Medical Officer for Scotland's realistic medicine strategy[5] suggests that patients ask these questions to make the right decisions about care; is this test, treatment, or procedure really needed? What are the potential benefits and risks? What are the possible side effects? Are there simpler, safer, or alternative