Letters

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Editor's choice

Consultation length matters

Euan Lawson is right to draw our attention to the length of the GP consultation in the UK.[1] Reference to martyrdom is not required. GPs and their practices have it within their gift to make the changes required to move from 10- to 15-minute consultations. We have recently done so at our own practice, and it would be fair to say that it has been the single most beneficial change in my 21 years at the practice. There has been a reduction in GP stress and anxiety (running late suits no one), morale has improved correspondingly, and patients are now given more time for their problems. We calculated that we would lose about 70 GP appointments across the week to achieve the change. In preparation for the move, these have been more than replaced by employment of nurse practitioners, a paramedic, a musculoskeletal FCP, and, most recently, a mental health nurse FCP.

Many practices are moving to 15-minute appointments, and we would urge others to plan to so do. We may even find it adds a few more precious years to GP careers.

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1. Lawson E. Debrief: Consultation length matters *Br J Gen Pract* 2019; DOI: https://doi.org/10.3399/bjgp19X702473.

DOI: https://doi.org/10.3399/bjgp19X704213

We need a clear vision for primary care

Euan Lawson argues that we could lengthen our consultation times.[1] Changing surgery times would destabilise practices already on the knife edge. Our partnership model developed in the 1960s and was still working well in the 1980s. Then, maybe we did see or speak to around 30 people a day, now suggested as a safe limit by the recent *Pulse* workload study.[2]

Young doctors won't commit to joining partnerships, where the capitation model compels doctors to process 40–60 appointments per day with a further punishing hundred or so clinical decisions to be made in letters, messages, or results. Yet senior GPs can't let go of it, with cost-rent, CCG money, and out-of-hours businesses paying their school fees and their pensions.

There is a danger that vested interest is holding us back. General practice is evidently broken, yet we flounder, debating continuity and telephone triage. We need a firm, shared vision for primary care that includes what a reasonable workload is, safe for us and for patients.

We need to be part of an organisation large enough not just to employ a multitude of colleagues — sub-specialist GPs, specialist nurses, extended-role practitioners, diagnostic physiotherapists, call handlers, pharmacologists (and more) — but also to train us. It will research and implement the structures able to assign the right person for each task. Our future organisations will be large enough to mesh with out-of-hours services. Appointments will be accessible. Our reformed service will regain first-world cancer outcomes and reverse deteriorating life expectancy.

Taking primary care into the future requires the College to rise above the vested interests of its officers. It needs to set standards for doctors in primary care that may not be achievable in partnerships existing today. With this model behind us, and a clear College ruling on what is a safe workload for one doctor in one day, we could confidently take to the streets. Ending 10-minute consultations with a new approach to primary care will enable us to offer something approaching excellence once again.

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2. Howarth J. Workload survey: 'We are working beyond the safe level'. *Pulse* 2019; **8 May:** http://www.pulsetoday.co.uk/news/hot-topics/pulses-gp-workload-survey/workload-survey-we-are-working-beyond-the-safe-level/20038667.article (accessed 12 Jun 2019).

DOI: https://doi.org/10.3399/bjgp19X704225

Doctors' ongoing education, empathy, and continuous emotional and psychological support for patients might help to deal with their medically unexplained symptoms

I very much appreciate the article about medically unexplained symptoms (MUS), as MUS is a very important disease entity. An ongoing doctor–patient relationship is the key to a satisfactory outcome of managing patients with MUS. We have to acknowledge the patient's symptoms and suffering by addressing their wishes of explaining their symptoms arising from their expressed physical and psychosocial concerns, giving continuing emotional support and empathy. Doctors should not make the situation worse, by stressing the fact that there is no serious underlying disease, or implying the fact that the patient is putting on or imagining their symptoms.[1]

We always have to have an open ear to new symptoms and review the diagnosis, as 10% of symptoms thought initially to be MUS turn out to be an organic disease, and patients with MUS can develop additional serious underlying diseases over time. Continuously reflecting on altering symptoms, avoiding diagnostic anchoring, and providing safety netting will help us not to overlook red-flag symptoms of possible serious underlying diseases.[2]