# LETTERS



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## MRCGP video component

I have recently completed my GP registrar year and the MRCGP examination, and feel that undertaking the video module was an experience that did not enable me to realistically demonstrate my communication skills nor my ability to be patient-centred.

The module was certainly far from doctor-centred. My video technology experience was admittedly poor, and learning how to set up, edit, and sort out numerous technical hitches proved to take up a considerable proportion of the seven months I spent filming.

Surely ticking 'criterion boxes' and measuring things that are measurable cannot assess the quality of communication in the consultation. Having to follow a rigid, 'Pendleton-like' model meant that consulations in which I used a patient-centred — but unstructured — 'narrative-based' model could not be submitted. It was not even worth entertaining the idea of using the 'transactional analysis' model.

My completed video seemed to be neither patient- nor doctor-centred; it was more 'College-centred' But communication skills must, crucially continue to be examined. Why not abandon the video and embrace the simulated surgery? Involve expert or stardardised patients? This may not prove to increase candidate's patient- centredness, but at least it would remove the intense frustration and stress that the video entails (so as not to sound bitter, I must add that I got a merit in my video!).


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I would like to say a few words in defence of the MRCGP exam, following recent correspondence questioning the suitability of the video component as a valid measure of competence,[1] on top of a general fashion for criticism in the medical press.[2]

I believe the 'active listening' aspect of the videos in particular has given me a more confident and effective consulting style, and yet all I seem to hear about the examination are criticisms about its relevance, importance, validity, and so on. The Royal College of Physicians or the Royal College of Surgeons may face similar problems, but realise that their exam is sufficiently popular among applicants and necessary to climb up the career ladder for them not to care too much, and consequently I don't hear many complaints from hospital colleagues, despite the much lower pass rates.

I would argue that these exams, and indeed those we did at medical school, are largely based on factual knowledge and do not acknowledge the holistic approach and communication skills currently advanced in the undergraduate curriculum, assessed in the MRCGP, and regarded by patients as increasingly more important.

It seems that those not wanting to do the MRCGP through apathy, laziness or fear of failure, either persuade themselves not to or are taken to denigrate every aspect of the exam which, they say, reflects the College's poor standing among 'grass-root' GPs. Indeed, some members become embarrassed, apologetic or dismissive of their qualification. Would those complaining about the exam be happy for one of their family to be treated by a senior health professional who explained away their lack of a specialist qualification in a similar manner?

This does not mean that I don't have problems with the exam — the political correctness, perpetuation of racial and cultural stereotypes, and somewhat obtuse nature of the multiple-choice question paper need to be recognised by the Module Convenors. Notwithstanding that, unchallenged criticism does nothing for the subdued morale of enthusiastic GPs, and strengthens the perception of general practice as a career for 'failed hospital doctors' rather than as a positive choice for senior house officers.


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2. Minerva. BMJ 2002; **325:** 1430.


Dr Peter Lyle's letter in the March issue[1] astonished me. I am a GP trainer too; other than being a Member I have no input whatsoever into the exam. Nevertheless, I can't accept his assertions. I would make several points to him.

The purpose of the tape is to demonstrate the ability to meet performance criteria, i.e. to be aware of the skills needed to do it. Surely no-one expects to do this at every consultation, any more than they expect not to cross hands on the steering wheel after passing their driving test? Very patient-centred doctors do not stay full-time GPs as long as less patient-centred colleagues. It's too hard to sustain. Don't try.

I advocate lists on the wall (although two-inch-square laminates that resemble a telephone number list on the telephone are more subtle). It's a reminder — few consultations are suitable for attaining all the points, and the care of the patient is paramount, not

ticking boxes. If it's not appropriate in a consultation, don't do it.

The effort in priming a patient for a video is far less work than doing it for real, which is a very hard thing to do. If anyone thinks of using actors, you are likely to lose more than your money. If caught you may lose your GMC registration, in my view quite correctly so.

I have made many videos of my own consultations. I can easily get seven consults and a 'pass' in six hours of video. If anyone can't, stop and reassess your technique: producing yet more video if you don't know what you are doing is not going to work. Believe me, I am not a great consulter, but I can pass! This is not hard to do — relax and enjoy your year, all you registrars. Don't get spooked by doom and gloom — that comes later!

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## Quality of referral letters

We welcome the study by Grol *et al*, which focused on communication at the interface.[1] We agree with the authors that this is an under-researched area with the potential to improve the care of patients. The referral letter can be viewed as a 'ticket of admission' for the patient on their journey into secondary care. We note, however, that the authors used two 'trained assessors' to measure the 'quality' of GP referral letters and that they based the assessment of 'quality' on national guidelines and the literature. While we understand the rationale for this approach, it highlights the lack of instruments to test the quality of GP referral letters. Not only are these instruments in short supply, but also few, if any, are based on consensus among a substantial number of practising GPs and relevant specialists. Over the past few years, our unit has published two such instruments to test the quality of referrals to colorectal and gynaecological specialists[2,3] and further work on instruments to test quality in referrals to other specialists is continuing.

With reference to the substantive conclusion of the study, we have published an analysis of semi-structured interviews with United Kingdom GPs, many of whom expressed the opinion that consultants do not always read referral letters and that letter writing requires a 'leap of imagination' about the information needs of the recipient of a referral letter.[4] We also reported the view that impoverished referral letters reflect poor quality of care received in primary care prior to referral in some cases. The key question that remains, despite this work, is whether the patients' experience of care received is substantially and demonstrably improved as a result of improved communication at the interface.

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4. Jiwa M, Burr J. GP letter writing in colorectal cancer: a qualitative study. *Curr Med Res Opin* 2002; **18(6):** 342-346.

## Headache in primary care

Leone Ridsdale's editorial[1] highlighting the issue of headache in primary care is most welcome. Headache is a very common presentation in general practice and there are more migraine sufferers in the UK than asthmatics and diabetics put together. We were disappointed, however, that there was no mention of the Migraine in Primary Care Association (MIPCA), which represents GPs, practice nurses and allied health professionals in the UK. MIPCA has launched guidelines on headache and migraine diagnosis that have recently been published[2] and they are available on the Internet.

We were also disappointed that triptan medication was described as expensive. Although the individual cost of a tablet is about £4 on average, usually only one tablet is required to abort most migraine attacks. The average migraine sufferer has 13 migraine attacks a year, so the real cost is quite low. Migraine is a disabling condition and patients deserve the most appropriate treatment.

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## GP pay — time to face facts

At first sight, Paul Hogkin's courageous, timely, blistering wake-up call to general practice[1] deserved better than a 'health warning' and Brian Keighley's somewhat pompous, complacent response.[2] That the general practice glass is both half full and half empty should be obvious to anyone with any nous, and while Hodgkin's hard truths may belie much that is to be celebrated in contemporary practice, they all have merit and are underrepresented in current debate.

Ask anyone in the NHS — GPs included — to complete the sentence 'The way to get GPs to do things is ...', and the answer will come ringing back, 'to pay them extra'. It is a curse on our profession and daily undermines the commitment and capacity to 'go the extra mile' that exemplifies primary care at its best.

Take the example of appraisal. Most of us appraise our staff. Until recently,

few of us appraised each other. One of our number recently killed several hundred patients simply while going about his duties. Under the circumstances, submitting to annual appraisal does not seem unreasonable. So how does our brave and noble profession respond? Only if you pay us extra. Only if it is unrelated to performance. Well, excuse me, but if our practice nurse started coming out with nonsense like that, she would be looking for a new post — but only once the section had elapsed. There is no credible position that backs paying appraisees, and paying over the odds to appraisers will simply encourage those who are 'in it for the money'. So why were responsible people so loath to stand up to the LMC apparatchiks? Because we have seriously lost the plot when it comes to money, and because too often we bale out the lowest common denominator mind set.

Take another example. 'Does Hodgkin really believe that £116 represents the cost of providing nine months' maternity care?' Is he serious? These people are already registered for General Medical Services. In many, if not most, practices, the vast proportion of maternity care is not provided by GPs until the postnatal check, now much reduced. So, in all, £116 covers possibly three brief consultations. What figure does Keighley have in mind? Hodgkin is unassailable on the childhood immunisation position, and it is interesting to note that Keighley does not even try to refute him here.

The last 'new' GP Contract rewarded both greed and dynamism. The proliferation of wart treatments under the guise of minor surgery and the removal of unimmunised children from medical lists were a smear on our professionalism, as were the excesses perpetrated by a minority of fundholders. On the other hand, there is something to be said for maintaining the entrepreneurial element, which is strong in general practice. It has enabled many practices to roll with central policy changes, prising out available advantages from the most unpromising positions, and innovating more rapidly than might have been the case within a salaried role.

The new GP contract offers the possibility that high quality care might, as Martin Roland has characterised it, be supported by the NHS rather than paid for out of the practitioners' pockets.[3] For it to be judged a success, GPs will have to approach it with generosity of spirit and openness, rather than looking for ever more ingenious ways of ripping it off. Then we may begin to lose the unwarranted prejudice of being the 'harlots' within the NHS.

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I read Dr Hodgkin's 'GP pay – naming the elephants' with interest and a degree of sympathy.[1] Dr Keighley's stout defence of the status of general practitioners seemed somehow less convincing.[2]

I feel that the issue is deeper than pay. General practice is changing at a remarkable pace. No longer do we aspire to provide 24-hour care and increasingly we are absent from the front line of primary health care. Patient care is being fragmented by the increasing number of nine-to-five part-time doctors (I'm one of them) and expanding teams in primary care. The idea of being the 'point of first contact' and knowing the family from 'cradle to grave' is being eroded.

The last decade saw the remarkable rise of the practice nurse. The next decade may well see a similar rise of the nurse practitioner. If that is so, then the role of the GP may change to that of being a specialist provider of primary care, sitting behind a front line provided by these other care workers.

Potentially, then, general practice as we know it is undergoing (another) revolution. The challenge for GPs as individuals is to cope with these changes. The challenge for the RCGP is to make itself relevant to the future primary care system as a whole, not just an increasingly small fragment.

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## NSAID use following skeletal trauma

The lifetime risk of any fracture at age 50 years is 53% among women, and 21% among men.[1] Non-steroidal anti-inflammatory drugs (NSAIDs) are frequently used in patients following trauma for their analgesic and anti-inflammatory properties, with more than $7 billion spent on this class of medication in the United States each year.[2] Evidence suggests that these drugs are detrimental to fracture healing, and may cause delayed or non-union. Glassman, in a review of 288 patients undergoing spinal fusion, showed that ketorolac significantly inhibited fusion,[3] Giannoudis noted a marked association in a retrospective review of factors leading to the non-union of 32 femoral diaphyseal fractures,[4] and Burd, reporting on a series of 112 patients prescribed indomethacin to prevent heterotopic ossification following acetabular and long bone surgery, had 26% more non-unions compared with the case-matched control group.[5]

A questionnaire was sent to all GPs in Northern Ireland, enquiring as to their prescribing preferences in patients following fractures. Results suggested that over two-thirds of GPs were using NSAIDs as part of their analgesic regime and that there was no difference in prescribing levels in injuries with high or low non-union rates. More than half of the responders were using NSAIDs in patients following compound tibial fractures. (These have a delayed/non-union rate of approximately 25%.[6])

With the development of newer COX-2 specific drugs, marketed as having an improved side-effect profile, along with ongoing research into new

indications for use, including migraine, Alzheimer's disease, schizophrenia, and as an anti-angiogenic drug in a range of tumours,[7,8] the prescription rate of these drugs is likely to continue to rise, with a possible consequent increase in the incidence of iatrogenic non-union.

Although NSAIDs do not delay fracture union in every patient, it would seem prudent that in those patients at an increased risk of developing non-union, other forms of analgesia are prescribed. These cases would include high energy or contaminated fractures, bones that, by their very nature, have a predisposition to develop non-union (waist of scaphoid, neck of talus, subcapital neck of femur and midshaft diaphyseal fractures), or patients with anaemia, malnutrition, or diabetes.

Many GPs take their lead in prescribing for these injuries from hospital discharge letters. It is therefore important that advice is given regarding appropriate analgesic prescribing. We suggest this could be done via improved communication in hospital discharge or fracture clinic letters.

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## Frequent attendance

Stewart and O'Dowd[1] should be applauded for their attempts to cast further light on the fascinating and complex issue of frequent attendance. However, applying similar methods in my own Leeds inner-city practice, albeit it with less extensive categorisation, did not reinforce some aspects of their research.

In particular, I encountered problems in the division of frequent attenders into clinically 'explicable' and 'inexplicable' subgroups and would question the robustness of this method. In terms of generalisability, I believe the operator bias would be of such significance as to invalidate a comparison between data from their study and others such as mine.

In a sample of 1640 patients (10.5% of the practice population), I identified 52 patients (3.17%) who attended on more than 12 occasions over the previous year. This compares with 1.95% (107/5342) of the population in the rural Ireland practice. Other distinctions were the younger mean age (43.2 years versus 51.3 years) of our patients and their higher mean number of long-term medications (5.82 versus 3.56 for 'clinically inexplicable' and 4.02 for 'clinically explicable' subgroups).

The female preponderance of the frequent attenders was similar in both Leeds and Ireland (73.1% versus 76%), as were the majority of characteristics of the age- and sex-matched controls in both practices. The mean consultation rates in the control groups were almost identical (3.36 versus 3.4). While this suggests that the burden of frequent attendance is greater in inner-city areas, it does not unmask the reasons for this discrepancy.

Clearly, there is value in distinguishing between those who 'warrant' this level of attendance and those who do not; however, labelling patients as such — even in the context of confidential clinical research — is precarious, given the drive for increasing openness, patient collaboration,[2] and avoidance of derogatory terminology. The seven partners in this practice, with experience in excess of 150 years, found the differentiation simplistic and disagreed vehemently about certain patients.

The large list size did not lend itself to easy recognition of patients, but it was the legitimacy of many patients' attendance that provided most difficulties. There was further discussion about how the subconscious tag of 'inexplicable' ascribed to some patients could jeopardise their care if genuine illness were to occur. I believe that accepting the existence of an heterogeneous but indefinable group of individuals with complex psychosocial circumstances is preferable to artificially splitting a spectrum of inexplicability.

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## Abortion and breast cancer risk

Gregory Gardner claims that induced abortion is the single most preventable cause of breast cancer.[1] However, he does not quote any evidence to substantiate this.

Gardner's third reference is a report (not peer-reviewed) based on mathematical modelling of international comparisons of abortion and fertility rates with breast cancer incidence. Spurious predictions are made from these data about future breast cancer incidence, and an unjustified causal link between induced abortion and breast cancer is claimed.

Davidson has summarised the meta-analyses and literature reviews on this subject to date.[2] While it is true that the meta-analysis quoted by Gardner[3] comes up with an odds ratio of 1.3, it included only case control studies. Three other reviews, which included cohort studies, also did not show an increase in breast cancer risk, albeit the data are not perfect.

One of the difficulties with this subject is that the case control studies (more than 20 of them) are subject to recall bias, with more under-reporting of abortion in the controls than the cases. However, this does not apply when record-linkage techniques are used or a cohort study is performed. There are four such studies now,[4] and none of them show a significant increase in breast cancer risk after exposure to induced abortion. The only conclusion that can be drawn from this evidence is that there is no effect of induced abortion on a woman's risk of breast cancer based on grade B evidence (fair evidence in support of the conclusion). It would seem unwarranted and, indeed, potentially damaging to mental health for professionals to raise this subject proactively when counselling women requesting and undergoing abortion.

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## Definitions of somatisation and cultural influences

We were very interested to read the systematic review, 'Beyond somatisation: a review of the understanding and treatment of medically unexplained physical symptoms (MUPs)' by Christopher Burton in the March issue of the *BJGP*.[1] It illustrates very clearly the difficulties in defining somatisation and how such patients might be identified in clinical practice for the purposes of research. However, Burton has not considered some of the cultural aspects of somatisation in his review.

We have just completed pilot studies examining the prevalence of 'somatisation' (MUPs) in primary care attenders from six different ethnic groups in the United Kingdom and Malaysia. We experienced considerable difficulty with regard to the cultural and operational definitions of somatisation for these studies. In multicultural societies, such as the UK and Malaysia, it can be very difficult to disentangle the reasons for attendance and distinguish 'cultural drivers' from true somatisation. For example, we observed that, in both the UK and Malaysia, the presentation of physical symptoms could be used by patients from different cultures as an 'admission ticket' to a consultant for validation of the 'sick role' or as a reluctance to admit to mental health problems. Language can also influence presentation. This makes it difficult to develop a working operational definition for the attending physicians to identify patients with MUPs. Is a patient with MUPs one who has no other way of expressing their psychological distress, or is it the patient who is conforming to the norms of their culture and health care system?

As Burton highlights well in his review, when researching this area there are other methodological difficulties arising from the lack of satisfactory operational definitions; for example, the ICD10, DSM IV, abridged somatisation and primary care definitions of somatisation are all different to some extent. The impact of this may be seen in the reported prevalence, which ranges from 0.06% to 22%.[2-4] Therefore, for intervention studies there is currently no sensible way to do sample size calculations without an agreed operational definition. In addition, such interventions, which do exist for the management and treatment of somatisation or MUPs in primary care, require more validation before they can become part of the therapeutic repertoire of general practice.

Burton reports only one randomised controlled trial of individual cognitive behavioural therapy based in primary care, and the results from a systematic review of other secondary care interventions are equivocal. All GPs and other clinicians are familiar with this phenomenon and yet it appears that no satisfactory intervention trials have been conducted in primary care.[5] There is clearly a gap in our knowledge and a great deal of research still needs to be done.

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