

Letters

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Genuine asylum?

Is it coincidence that you happen to have two interesting but not surprisingly related articles in the January 2006 issue of *The Back Pages* — Vernon and Feldman¹ on health care of asylum seekers and Jennifer Marsden² on a comparison of health care provided on either side of the Atlantic?

Both papers touch on the same theme of the response and duty of government. The primary responsibility of a government is to protect its citizens and care for them.

Marsden acknowledges a capitalist system that fails to provide a safety net in health care for the many millions of Americans who are, therefore, effectively disenfranchised in the health system of that country.

Vernon and Feldman describe the plight of failed asylum seekers vis-à-vis medical care in the UK. While this is a matter of concern, one needs to look at it from the perspective of the duty of government to care for all its citizens, that is, those who have a right of abode in the UK.

One of the problems facing the authorities is the difficulty of establishing the bona fides of asylum seekers and so distinguishing them from those who seek to enter and stay in the country for other than genuine humanitarian reasons. While there is, no doubt, an overwhelming obligation on the part of any government to provide succour to those in need, the definition of 'need' is now a matter not only of debate but also of concern. The large numbers of people entering the country illegally and who disappear should concern us all. Additionally, it cannot be right for the UK to provide comprehensive health care for people who have failed the tests of asylum.

If the authorities claim that channels

for appeal have been exhausted and that there is no right to reside in the UK, then it is imperative that the person concerned is speedily, but humanely, returned to his/her land of residence or port of embarkation to the UK. Until such time that this happens such a person should be able to access all the facilities of the NHS as a citizen of the UK is entitled to. It should not be left for the NHS to implement the law.

This would help, at least partially, to address the increasing disquiet felt and expressed by patients of the difficulties of obtaining their own treatments.

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Competing Interests

None.

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Comparing GP and nurse practitioner consultations

Seale *et al*¹ have provided a much-needed comparative analysis of the different communication patterns used by GPs and nurse practitioners in their consultations with general practice patients. Their findings, namely that nurse practitioners conduct longer consultations with increased dialogue by both patient and nurse practitioners alike has resonance with previous consultation research regarding variant communication

styles among doctors and nurses².

However, while acknowledging that a longer consultation time may have a short-term adverse economic effect, it must also be noted that high levels of patient satisfaction with medical consultations have been consistently associated with higher levels of patient adherence and subsequent quicker recovery from illness or injury, with all of its associated social, psychological and long-term economic benefits.^{3,4} In this context, a focus on patient satisfaction in the management of 'same day' patients, as exemplified by the observed nurse practitioner consultations, would appear to be a prudent economic choice.

A further point of interest is the nurse practitioners' emphases on 'social/emotional/patient-centred' talk in their consultations. This feature of patient-centred talk is an iterative finding of research regarding the nurse practitioner consultation, which has previously been identified both in my own research⁵ and also in the work of Johnson.⁶ In a landmark study of doctor-patient interactions, Mishler⁷ warns of the dangers of neglecting patients' perspectives in consultations, noting that patients accentuate the 'voice of the lifeworld', reflecting the subjectivities of everyday life, while in response doctors tend to emphasise the 'voice of medicine' as seen in their usage of objective scientific analyses in consultations. Mishler contends that this disparity of focus between doctors and patients in consultations results in ineffective medical care, as patients feel that their concerns are not being met, which has a subsequent detrimental effect on patient satisfaction, which in turn adversely affects patients' compliance with suggested medical treatments. In this sense it would appear that the nurse practitioners in Seale *et al*'s study were responding in an appropriate contextual

manner to their patient's concerns even though they were dealing with 'same day' presentations.

Finally, with the planned extension to nurse prescribing it can be presumed that nurse practitioner consultation time lengths may shorten as they will no longer be discussing with patients the arrangements for getting prescriptions signed.

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Deprived people less likely to get treatment to prevent heart disease

At Nottingham City PCT, with our own set of inequalities due to deprivation, we were very interested to read Peter Brindle *et al's* powerful paper.¹

It is clearly an important issue that the recommended risk assessment tools may be contributing to these health inequalities.

I have three questions I would like to

invite the authors to comment on:

1. For our deprived areas of Nottingham, what practical implications does this have? I hope it will not be long until the QOF addresses primary prevention but at present at the practice level we have no means of altering primary care activity. Perhaps we could all look at those in the deprived areas who are at increased vascular risk but who currently score below the threshold for action with renewed priority ... to help reduce the inequalities rather than further increase them.
2. Table 2 of the paper highlights considerable differences between the Framingham and the less healthy Scottish populations. Presumably there are also some differences between Scottish and English populations; is it a measure of dietary or deprivation differences generally? In interpreting this paper south of the border how should we take account of these differences?
3. Finally, how, I wonder, do the authors see this evidence being taken forward so that change happens in the way we make objective assessments of risk? I am aware of other risk tools such as www.riskscore.org.uk which is also based on data outside of the UK. Is there a better tool for us to use at the practice level?

In the meantime, the challenge to us all is to look wider at 'whole person risk', including ethnicity, and employ clinical judgement, recognising the influence of the non-Framingham risk factors.

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Author's response

I am grateful to Stephen Willott for his interest in our paper, and I am pleased

he has responded with three very challenging and current questions. Our paper and other work suggest that the Framingham risk score underestimates cardiovascular disease risk in people from deprived areas and with low socioeconomic status relative to more affluent people.^{1,2} This fits with a body of work showing that risk scores tend to under predict in high-risk populations and over predict in low-risk populations. The reason for this is that the limited number of variables in a risk score developed in one population, cannot fully account for variations in risk when applied to other populations. Currently, we can only speculate about what risk factors are missing from the Framingham equation that social deprivation seems to be a surrogate for. Dietary differences may indeed be one of them.

Willott notes that national differences in disease rates exist, but greater differences exist within countries. For example, there is a 10-year difference in life expectancy between two parts of Bristol only 3 miles apart. Currently, there is no 'off the shelf' risk calculator that adjusts the Framingham score for these differences, but the data is available to develop it and national guideline bodies have noted the limitations of the current system. When appropriate adjustments for social deprivation are made, the distribution of resources needed to implement these adjustments should recognise the increased workload of practices serving deprived areas.

Willott recognises ethnicity as another limitation of the present system. ETHRISK, a web-based risk calculator currently undergoing peer review, provides some guidance in that area.³ There is likely to be a significant interaction between ethnicity and social deprivation that needs to be recognised and further evaluated, as it makes no sense to adjust for ethnicity and then social deprivation if both factors are present in the same person. Until the Framingham risk score is modified, it remains in its current form the best available guide to targeting preventive treatment. As Willott suggests, it should