Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them via email to **tmarszalek@rcgp.org.uk**, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

Using common ophthalmologic jargon in correspondence can lead to miscommunication

The usage of abbreviations and acronyms is increasingly becoming accepted as part and parcel of the medical language.[1] In recent times we have seen an almost exponential increase in the use of such shortened terms in almost every speciality of medicine,[2] with the ophthalmic field being of no exception. Such abbreviations are used almost everyday by hospital clinicians in their correspondence with primary healthcare doctors.

Although acronyms are useful because they simplify and accelerate communication, specialists often take it for granted that certain trade terms are evident or self-explanatory such that they do not bother to define them.

The inappropriate use of jargon can lead to confusion and miscommunication between the ophthalmologists and the GPs; with the patient potentially suffering due to misdiagnosis or maltreatment.

In a primary healthcare survey we undertook, sending out a 'jargon' questionnaire to GPs based in Wales, asking each recipient to unravel 12 abbreviations to the best of their ability; we found quite surprising results.

Out of the 48 questionnaires we received, we found quite wide variance in the understanding of GPs for the meanings of 12 ophthalmologic abbreviations we presented. As few as 16.7% of GPs responded correctly to what the term, 'PVD' (posterior vitreous detachment) represented, with 32 of the responders offering 'peripheral vascular disease' as an explanation. However, 68.8% of GPs were able to correctly define what 'Left RD repair' meant. Startlingly, 67.8% of all the responses received were incorrectly defined or explained.

The results of our survey suggest that many of the acronyms used by ophthalmologists are often poorly understood among GPs. Such misunderstanding may create confusion both to the GP themselves and to the patient who may be presented with different diagnoses. Ophthalmologists have a duty of care to ensure that GPs are aware of the meanings of such terms used in their discharge summaries and outpatient letters.

We propose that to ensure GPs fully understand what such acronyms mean and to avert mishaps, eliminating any guesswork, one should avoid the usage of acronyms that denote common non-ophthalmic conditions such as PVD. Specialist terms such as 'pseudophakia' should be replaced with the full procedural detail of the operation undertaken. Finally, when mentioning any acronym in such communiqués, the ophthalmologist must ensure that they are fully explained to avoid any confusion that could later be detrimental to patient health and care.

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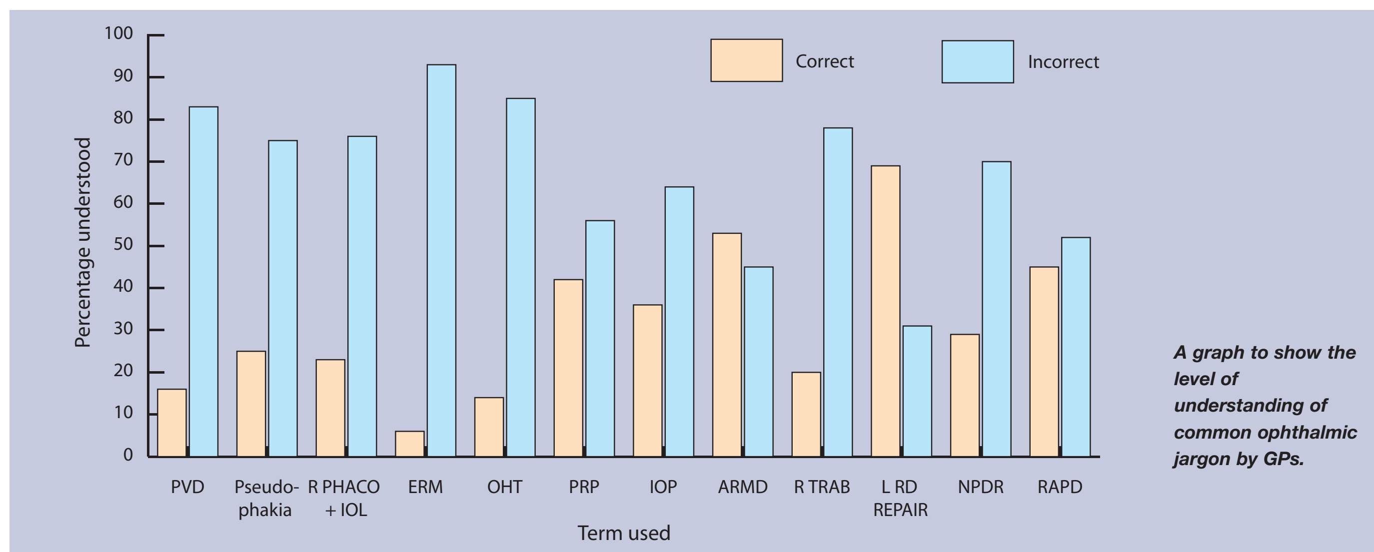

A graph to show the level of understanding of common ophthalmic jargon by GPs.

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Questions about COPD

The subeditor on my student paper would never let us end a headline with a question mark: the writer should be clear about what they are saying. Rupert Jones restates the question early in his leader on chronic obstructive pulmonary disease:[1] 'we need to know whether there are effective strategies to stop people with early disease progressing, and if so, how to detect the disease early'. Without providing convincing evidence he ends with what seems like an answer: 'early diagnosis and active management can make real differences to the millions suffering to breathe' but use of the word 'can' rather than 'does' veils continuing uncertainty. The list of pharmaceutical sponsors and commercial interests, creditably included, helps us to weigh his views appropriately. His 'advice for any individual with early airflow obstruction needs to be that they may be at higher risk, but not that they are at the start of a relentlessly progressive disease whose course can only be changed by stopping smoking'. Leader writers and doctors should be clear about what we are saying: people — especially those with airflow obstruction — should stop smoking.

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Early diagnosis of COPD

The article regarding early diagnosis of COPD[1] was of particular interest, as our practice has recently implemented a Structured Systematic Screening Programme for the Early Detection of COPD. Patients are identified by case finding in routine surgeries and in both current and ex-smokers, those calculated to be 'at-risk' (over 40 years, with history of 15-pack-years or greater)[2] are subsequently invited for spirometry with the specialist nurse practitioner. This also triggers smoking cessation advice if appropriate. After 10 months, 56% of the target population have their risk documented, and of those, 45% have undergone spirometry. Thirty-five per cent of patients on the current COPD register were diagnosed through this initiative; an increase of 54% on the register held at the start, supporting beliefs that COPD is grossly under-diagnosed and consequently under-treated.[3]

As a large and increasing cause of worldwide mortality and morbidity, COPD cannot be ignored. Actively targeting those at risk allows optimal management and specific health promotion for example, vaccination. Recent work also suggests that diagnosing early airways obstruction in asymptomatic smokers does increase cessation rates,[4] thus preventing disease progression, and fuelling the argument that initiatives such as this are indeed of great health and economic benefit, and should be more widely employed.

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Appropriate postgraduate training

It's not often that this unreconstructed Essex boy finds himself gazing wistfully north of the M25 but such was the effect of Elaine McNaughton's editorial[1] describing an innovative programme for GP speciality training in Angus. I couldn't help but contrast life as described in the East Deanery of Scotland with that we are presently experiencing in the Eastern Deanery of England.

McNaughton rightly stresses that a meaningful implementation of Modernising Medical Careers (MMC) demands training programmes that not only provide doctors specialising in general practice with the required competencies but also are attractive enough to encourage high calibre doctors into the speciality. The programme she describes attempts to meet these challenges and provides a useful model for elsewhere. The main problem with innovation is that you have to be able to implement it and, in our part of the UK, we are hitting something of a reality gap.

Course organisers in the Eastern Deanery have spent the past 3 years busily designing their schemes in preparation for MMC and very good some of them looked too. In late August we were informed that, contrary to repeated assurances, funding had not been obtained to support 18 months in practice-based training and we were asked to re-design our schemes to include 2 years in hospital posts. The Deanery is now involved in frantic negotiations with the Trusts to 'badge' sufficient hospital posts and with general practice being at the end of a long queue, it's difficult to be