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April Focus

A few months ago in this column I quoted my friend's desire to rewrite the medical textbooks. On page 273 Nick Summerton opens his review of medical history as diagnostic technology by asking whether it has become redundant. His own answer, perhaps predictably, is a negative. Not only is a good history essential if the expensive modern diagnostic technologies are going to work at all, but he argues that we are now in a position to understand much better what different symptoms and signs really mean. There are surprises in store, for instance: 'In relation to the diagnosis of pneumonia in a patient with a cough, eliciting a history of sputum production merely affords an additional positive likelihood ratio of 1.3' (page 274). Our ignorance of the weight to be attached to common signs and symptoms is a major stumbling block at present.

Take illness in children, one of this month's themes. The paper on page 236 reports what GPs say they use when assessing sick children. Most readers will not be surprised with the conclusion that 'With the exception of temperature, vital signs were uncommonly measured … '. In the Netherlands, the study looking at what predicted whether calls to a cooperative were followed by a consultation or not reported similarly unsurprising results (page 242). There were differences between younger and older children with the older children more likely to be seen if they had prolonged high temperatures, drowsiness, or pale skin.

The difficulty with both of these studies is that the findings reflect a consensus more than any hard evidence that such features reliably predict more serious illness. This is not a failing on the part of the GPs, but a reflection of the dearth of reliable evidence on which to base clinical practice, the same ignorance as above.

The accompanying editorial on page 228 points out that there are a lot of data, but very little gathered from primary care studies. As we all know, a big element of managing sickness in children is exploring and dealing with the parental concerns, and it's reassuring to learn that: 'Children without alarm symptoms were more likely to be seen when the parents were moderately or seriously concerned' (page 246), just as children with cough were more likely to consult their GPs in normal hours when the parents were worried, or when they were encouraged to consult by their families (page 248).

One of the reasons that James Cave gives for encouraging us to record vital signs in children is the fragmentation of primary care between daytime and out-of-hours providers, a reminder that we are always sharing the responsibility for care. It's more familiar in palliative care, when there is a conscious awareness of teamworking. The paper on page 264 sets out pretty clearly what our fellow professionals do (and don't) value in us: responsiveness and good communication; respect towards our colleagues; and involving them early on.

GPs in the UK, who have a well-deserved reputation for gaming any system, may be surprised to learn that the community nurses have become adept at gaming them in order to get their attention. The need for good communication is echoed by the study on page 256 looking specifically at practices that are working to the Gold Standards Framework, and it also emphasises the value of the meetings prescribed by the framework. Ros Bryar's editorial puts these findings into a theoretical perspective, and also points out that teamwork within practices has to happen within a larger organisational framework (page 231).

Assessing the quality of palliative care is still directed much more at the process of care than at any agreed outcomes, and that is at least partly because of the practical and ethical difficulties of research in terminal illness. One possible outcome is the number of patients who die at home, but Stephen Barclay and Antony Arthur question whether it should be accorded such importance (page 229).

Here in the UK responding to research is not the end. Quite rightly we are expected to make the services responsive to patients, though I for one am sceptical that annual surveys and patient groups is the way to get to the right answer. Norman Gland's surgery has asked him to join a patient group, with results to strike terror in the doctors (page 292). Except that for him it became therapeutic. Has the surgery found a cure, albeit temporary, for all somatising patients?

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