New GP writing

Hurricane 'Catriona'

Let's not exaggerate the force of the hurricane that cut a swathe across central Scotland on Thursday 8 December 2011. It wasn't Katrina. A few roofs came off, a few trees came down, and a few cars were squashed. I went into work on Friday to find we had no electricity in Aberfoyle (we have two dispensing practices in villages 7 miles apart), and, while we had heating and lighting in Buchlyvie, the computers had crashed. I spent most of the day seeing patients in Buchlyvie.

It was a tremendously exhilarating experience. No EMIS, no Docman. The screens were blank. I started out thinking that the loss of access to the patient record would be, though far from insurmountable, an impediment. In fact, the collective memory of patient and doctor easily compensated, and I quickly came to appreciate the advantages of being liberated from the Third Eye in the room. It was all a question of Focus: I and the patient were able to turn our backs, literally, on all the paraphernalia of IT, and concentrate on one another. That I was able to give the patient my undivided attention became self-evident. The sharper focus of the patients was more subtle; they were aware that we were operating under constraints, and that therefore it behoved them to be candid, succinct, and to the point. From an ethical point of view it was as if the patients had suddenly become aware of the concept of 'justice' and of the moral imperative that they see their own problems in the context of the individual and collective problems of the community, to retain a sense of proportion about the extent and limit of their own personal needs. It was as if we were operating in a war-time footing.

There was a blitzy atmosphere of camaraderie among all the staff. Suddenly we were all talking to one another. If we encountered a difficulty we improvised, in good faith and to the best of our ability. We had a great day.

Would I want to dump all the computers in a landfill? Of course not. We have crossed a Rubicon there. But it is all a question of proportion. On that Friday morning when we realised the system had crashed, some management scientist in an obscure recess of the Health Board allegedly suggested, without any trace of irony, that we pack up and go home. Nothing could be more redolent of the insanity of our devotion to cyber technology than this suggestion that, on a day when, for example, our most elderly patients might be at their most vulnerable, we doctors might consider ourselves effete just because we couldn't turn the computer on. It's just a tool. EMIS or GPASS or Vision are just fancy versions of a Lloyd George envelope. That's all. If we really think the essence of what we do is somehow enshrined in a PC then not only have we lost our way; we have lost the plot. We have lost our humanity.

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Dr Imposter

An award-winning health journalist poses as a locum GP to expose the truth about general practice.

I know it's not strictly legal, but I'm doing this is in the public interest. General practice is not well. GPs are paid more than the prime minister just for referring you to a proper doctor. You can never see the same doctor, and don't even try getting an appointment to fit around shopping or the school run. Even reasonable people like me are getting thrown off GPs' lists just for missing a few appointments. So I am going undercover as a locum GP to lift the lid on general practice, and to find out what the hell's going on at the other end of the stethoscope.

Don't worry — I am not putting patients' health at risk. Although I'm not medically qualified in the traditional sense, I do have GCSE biology, and I am an experienced freelance health journalist. I've covered most of the big health stories of the last decade, from the scandal of statins to the breakthrough of using acupuncture to cure dietary allergies. I've even worked as health features editor for *Preggers!* magazine for a year, where I commissioned an award-winning article on celebrities' pregnancy-induced piles. And of course, I'm a fully qualified mum too. I have a 4 year-old daughter, Lettis, so there's not much I don't know about ear aches, fevers, and Calpol®; certainly more than the baby-faced 'doctors' at the surgery who lecture my nanny every time she takes Lettis in. So although my formal degree is in media studies from London Metropolitan, my informal qualification is in common sense medicine from the University of Motherhood and Health Journalism.

I sometimes get butterflies in my stomach when I imagine what my first solo surgery will be like. But I'm sure I'll be fine — I've done my research. I have hacked into doctors' chat forums, and befriended some GP registrars (always up for a free drink) in my local pub. I have uncovered four golden rules to surviving as a GP, and if I stick to those I can't go far wrong:

1. Communication is 90% of the job. Be nice, listen to patients, and involve them in decisions, and you're very unlikely to

get any complaints (however hopeless you are at real medicine). The evidence from medical protection societies backs this up.

2. You only need to know about 10 medicines really well — that should cover most problems, from high blood pressure to urine infections. Steroid or antibiotic creams work for most skin rashes.
3. It's considered professional to know your limits and that means you can look things up. The *British National Formulary* (*BNF*) is a sort of doctors' bible on drugs and explains everything you need to know about prescribing in the UK. Anything else, you can look up on a website called *GP Notebook* — an online textbook of general practice, covering most things you're likely to see.
4. Anything not covered by 1–3; refer to a specialist.

How hard can it be? I can't wait.

Dr Imposter exists only in the imagination of the author, and no real patients have come to harm in the writing of this column.

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Tobacco harm reduction: thinking the unthinkable

We all know smokers who can't or simply won't stop smoking. They cough, they wheeze, and they completely fail to respond to our NICE-approved brief interventions, indifferent cajoling, or spittle-flecked threats of impending doom. It has been over 60 years since Doll and Hill published the landmark study on the harmful effects of smoking yet since then millions of Britons have died of tobacco-related disease.[1] Doctors offer up a stark choice to patients: stop smoking or die. The profession has a visceral hatred of Big Tobacco but it is clouding our judgement when it comes to public health policy. Faced with the potential of a billion smoking-related deaths in the 21st century we need to consider a third way: tobacco harm reduction.

Smokeless tobacco comes in a variety of forms; Swedish-style snus is a moist tobacco product placed under the upper lip. E-cigarettes produce a vapour composed of water, propylene glycol, and nicotine, so users are not exposed to all the toxicants, the carcinogens, and the free radicals formed when tobacco is burned. We know how staggeringly difficult it is to give up smoking. Cessation rates for smokers are rarely better than 10% and in people with mental illness or other addictions, smoking remains near ubiquitous. The most disadvantaged groups in society pay the biggest price with devastating health consequences that widen inequalities.[2]

The Royal College of Physicians published a report in 2007 which recognised the case for tobacco harm reduction and NICE will publish guidance on the topic in 2013.[2] The reduction of harm from smokeless tobacco is around 98–99%. The evidence that smokeless tobacco acts as a 'gateway' to cigarettes is not there. The concern that smokeless tobacco will deter and delay full abstinence is dwarfed by the mathematical relationship governed by the relative risks. If this wasn't tobacco and if there wasn't the bogeyman of Big Tobacco casting his shadow it would be a no-brainer. We all know that nicotine is highly addictive, but the harm from cigarettes comes from all the other substances piggy-backing, not the nicotine per se. One back-of-a-fag-packet calculation has suggested that smoking for just 1 month is more dangerous than switching to a smokeless nicotine product for a lifetime.[3] It could save millions of lives.

The opposition to smokeless tobacco verges on the fanatical. Perhaps it's an understandable gut response from the health profession who have borne witness to the misery and death inflicted by tobacco but, whether it is Swedish-style snus or e-cigarettes, we need to recognise that the health risks associated with these are several orders of magnitude less compared with normal cigarettes. For some it is unthinkable but GPs, who pride themselves on their pragmatic patient-centred approach to medicine, need to keep an open mind to the potential of tobacco harm reduction to benefit our patients. The next time you are faced with a raddled, wrinkled smoker unable or unwilling to stop it may be worth remembering the third way.

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