Letters

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Leonardo da Vinci

I suppose that many of us would choose to have known Leonardo da Vinci of all possible historical figures. I count myself most unfortunate, therefore, to have missed the opportunity when I read in the first lines of the June *BJGP*[1] that 'It's almost exactly half a century since Leonardo da Vinci made his beautiful drawings of the heart valves'. I would have been 19 at the time, by your reckoning, and would have saved what I could from my student allowance to hasten over to Italy for the privilege of sitting at the feet of the great man. Pity, opportunity missed ... sadly.

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Low-level exposure to carbon monoxide

The diagnosis of chronic, low-level exposure to carbon monoxide (CO) remains an enduring challenge for physicians worldwide.[1,2] A colourless, odourless, and tasteless gas, CO is undetectable by exposed individuals.[3] At the same time, as a product of incomplete combustion of carbon containing compounds, it may be readily produced in domestic settings where fossil fuels (coal, oil, gas) and wood are used.[3]

The UK Department of Health (DoH) recently provided an estimate of 4000 attendances to emergency departments (EDs) due to CO poisoning and around 50 fatalities annually[4] due to accidental exposure. Every year approximately 250 000 gas appliances are condemned in the UK; if only a proportion of these were emitting CO then the true numbers of CO poisoning are likely to be considerably higher.[5]

The difficulty in recognising cases of low-level exposure has been well documented in the literature.[1,2,6,7] This is mainly on account of the non-specificity of symptoms with which cases may present, such as headache, flu-like illness, fatigue, difficulty concentrating, and diarrhoea. Although the majority of presentations to primary care with such non-specific symptoms will probably not be cases of CO poisoning, prompt identification of patients in whom symptoms are due to CO exposure is clinically very important so systems can be put into place to minimise further harm.

To aid management of CO-poisoning cases in primary care, we propose 'COMA', an *aide-mémoire* to quickly identify cases of possible CO poisoning as well as a teaching aid for junior staff. Four questions to be asked to patients can be remembered by the acronym 'COMA':

C: Cohabitees/companions: is anyone else in the property affected (including pets)?
O: Outdoors: do your symptoms improve when out of the building? (better outdoors)
M: Maintenance: are your fuel-burning appliances and vents properly maintained?
A: Alarm: do you have a carbon monoxide alarm?

We hope that this *aide-mémoire* can be of use in raising awareness of CO poisoning in general practice and that its brevity and ease of use will make it a useful frontline tool in the identification of chronic cases of CO poisoning.

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Do GPs really provide 47 minutes a year for the patient?

The recently published RCGP report on medical generalism brings into focus the need for GPs to spend more time with patients to deliver high quality generalist care.[1] Historically, the figure of 47 minutes a year for the patient has been widely cited and discussed as a summary statistic for the total consultation time a GP spends with each patient per year.[2–4] This figure was first proposed in 1998 by Professor Sir Dennis Pereira Gray as a challenge to the '7-minute consultation' summary statistic of the day.[5] The figure was based on a calculation using data from the Doctors' and Dentists' Review Board (DDRB) workload survey and the General Household survey (GHS), now known as the General Lifestyle survey (GLS).[6,7]

Average consultation length (DDRB) x
Average number of consultations per year (GHS)
= Total time with patient per year

The DDRB consultation length figure is

Table. Consultation length

Year	Mean consultation length (mins)	Mean number of GP consultations/ year (GHS)	Mean number of consultations (any health professional)/ year (NHS IC)	Mean number of consultations with a GP/ year (NHS IC)	Total time/ year (using GHS) (mins)	Total time/ year (using NHS IC)
1997	9.37	5	4.01	2.92	47	27.8
2006	11.7	4	5.22	3.23	47	37.8
2008	—	—	5.5	3.4	—	—

based on practice survey data and is estimated by dividing the average length of surgeries by the average number of patients seen.[8] The GHS figure is based on patient recall of consultations with the GP during the last two weeks and multiplied by 26.9.

The GHS figures were reported to be broadly comparable with data published by the 2009 NHS Information Centre report that was based on trends in consultation rates calculated from computerised clinical records (QRESEARCH®).[10] However, unlike the GHS, the NHS Information Centre (NHS IC) report provides a detailed breakdown for which primary care health professional the patient consulted (GP, nurse practitioner, or other). If the NHS IC figure is used to calculate the summary statistic instead of the GHS then it appears that the total time the patient spends with a GP may be less than 47 minutes (Table).

GHS data suggests total annual contact time remained the same (47 minutes) between 1997 and 2006, largely as a consequence of longer consultations in the face of a falling average number of consultations. In contrast the NHS IC data indicates that while total annual contact time with any health professional increased during this period, the total time spent with a GP has always been less than 47 minutes, reaching just under 38 minutes in 2006.

Clearly great caution is required when combining, interpreting, and generalising such crude summary statistics. The DDRB report acknowledges that the methodology used to estimate consultation length, dividing the average length of surgeries by the average number of patients seen, may over estimate consultation length (for example, by including interruptions and time spent waiting for patients to arrive/leave the room).[8] Both the NHS IC and GHS demonstrate considerable variation in consultation rate according to variables such as age, sex, location, etc. The full NHS IC report is strengthened by adopting a number of methodological approaches to the data including various measurements of error, and weighted linear regression techniques.[10] However, the figures presented raise several important points for reflection.

While 38 minutes is still a reasonable amount of time it may be a more sobering figure than that of 47 minutes. In reality, this figure could be even less given potential over estimation in the DDRB data. Furthermore, the 38-minute summary figure relates to the amount of time spent with any GP, we should not assume that it is representative of the time a patient spends with the same GP. This may bring into sharper focus the limited space for providing continuity of personal care and just how important each second we spend with each patient really is.

Perhaps the real summary statistic of interest is the amount of time a given patient spends with the same GP each year?

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Co-payments and a just health service

The introduction of co-payments as a means of affording a just health service in times of austerity is suggested by David Jewell.[1] In reality they have existed for some time in many European countries, including Italy where there is a national health service very similar to that of the UK.

The National Institute for Health and Clinical Excellence is approving at least some of these new approaches. In Italy there is one filter, the LEA (Essential Level of Assistance), which considers every year what should be deemed essential and thus totally free. The only way to keep within budget is to restrict what is provided, and clearly inform patients that some services will no longer be available as totally free for all.

In Italy everything is free for patients who are declared as 'poor'. There are very few subsidies for the 'not-so-poor' with chronic conditions. For all others, charges on visits, procedures, and prescriptions are still subsidised, but to a maximum of €50. Additionally, a larger number of commentators see benefit in having at least some co-payments applied. There is even a triage system for hospital emergency rooms whereby some patients incur a charge. Co-payments can be made for higher quality meals for example.

For primary care attendances, some are advocating a nominal payment for every GP consultation to prevent the recent growing, and overwhelming, access to crowded practices for non-problems or for frequent attenders availing themselves of a free service. A 'ticket booklet' is therefore under consideration in some countries such as Germany.

The vigorous growth of private health