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

insurance is currently curtailed due to major national, even international, financial crises.

The introduction of a co-payment system would simply maximise inequity, burdening especially those who already pay as a proportion of their income, the most for their health care, often for the management of chronic conditions. Raising co-payments in proportion with people's income (in three or more levels) could be a sensible choice, but there is the risk that many 'rich' and also 'not-so-rich' people will not use the NHS, choosing instead some 'low cost' (that is almost the same of co-payment or little more) private poli-specialistic services, as the ones now growing in Italy.

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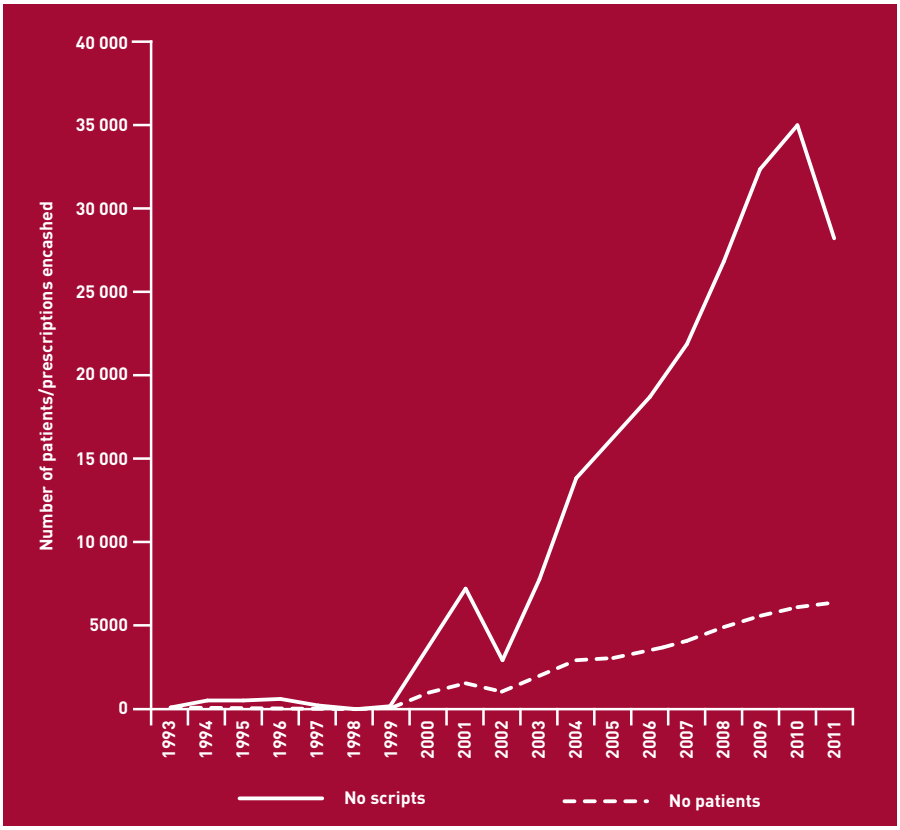
Substance misuse of gabapentin

Neuropathic pain affects up to 8% of the population,[1] causing significant distress and morbidity. Good evidence-based treatment is available,[2] so early diagnosis is important. Recent publicity and guidelines, and increasing prevalences of age-related causes of neuropathic pain (including postherpetic neuralgia and diabetic neuropathy), have led to increasing rates of diagnosis and treatment in primary care. Gabapentin is one of the recommended mainstays of evidence-based treatment.[3]

Unfortunately, our clinical experience suggests that gabapentin is now prevalent as a drug of abuse. The drug's effects vary with the user, dosage, past experience, psychiatric history, and expectations. Individuals describe varying experiences with gabapentin abuse, including: euphoria, improved sociability, a marijuana-like 'high', relaxation, and sense of calm, although not all reports are positive (for example, 'zombie-like' effects). In primary care, an increasing number and urgency of prescription requests cannot necessarily be explained by the increased number of cases of neuropathic pain. In the substance misuse service, the numbers admitting to using gabapentin (local street name: 'gabbies', approx £1 per 300 mg) are also growing.



Prescribing data from the Tayside region of Scotland show a rise in the number of patients receiving gabapentin, and an exponential rise in the total number of prescriptions issued, particularly since it was licenced for postherpetic neuralgia in 2002 (Figure). In the substance misuse services in Tayside in 2009, we found that of those who had been attending for at least 4 years (n = 251), 5.2% were currently receiving gabapentin on prescription, with a mean dose of 1343 mg, and were >3 times more likely to admit to non-medical use of analgesics (P = 0.006). Meanwhile, of 1400 postmortem examinations in Central, Tayside, and Fife regions of Scotland in 2011, 48 included gabapentin in their toxicology report, with 36 also including morphine and/or methadone, indicating recent possible opioid dependence. Gabapentin is easily prescribed without restriction, and escalating doses are recommended.[3,4] It is therefore easy to facilitate any misuse and addiction potential, and to stock the black market. A recent police report indicates the increasing tendency to use gabapentin as a 'cutting agent' in street heroin (and to recover gabapentin on the street and in prisons), further adding to the abuse and danger potential.[5] Like opiates, gabapentin is fatal in overdose; unlike opiates, there is no antidote and the long half-life instils the need for prolonged, intensive management of overdose.

The epidemiology of gabapentin misuse needs further detailed and urgent assessment, including cross-linking data from Police, NHS, and other sources. We should consider introducing routine gabapentin testing in urine drug screens. This will inform clinical and political approaches to this possible new and dangerous type of substance misuse, as well as safe management of the distress caused by neuropathic pain.

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