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Use of email for consulting with patients in general practice

In this interesting editorial, Helen Atherton discusses the use of emails for consulting with patients.¹ The consultation is at the core of general practice. With the patient in front of us in the consulting room, we are able to interact and engage with them, develop a rapport, and nurture the doctor–patient relationship. We have the opportunity to get to know our patients along with their families on an individual and personal level. Face-to-face, we also learn about our patients from their non-verbal cues, demeanor, and attire. This assists us in understanding our patients and their needs as a whole, beyond their health needs. When I signed up to GP training, I did so because I was excited about this idea of delivering a personal and holistic service. A few lines in some form of email consultation seems incomplete, impersonal, and lacks the patient-centeredness, family-centeredness, and holism that GPs are encouraged to aspire towards.²

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Sharing control of appointment length with patients in general practice

I was interested to see Rod Sampson's article;¹ many years ago I read something similar, and decided to try it myself, albeit without the post-appointment interviews. We offered my patients 5, 10, 15, or 20-minute appointments; it worked very well; I was pleasantly surprised. Patients had a good idea of how much time they would need; very few requested the longer 'slots' so my fears of being overwhelmed proved unfounded.

We did not continue the experiment because at the time I had a policy of accepting phone calls from patients; this interrupted the consultation (although if I let the phone ring more than three times the receptionist understood that I was not going to answer) but saved having to ring back, with the problems that engendered for the patient in terms of having to stay by the phone for an unpredictable period of time. However, what happened was that for each phone call, I ran that little bit late, so if there were several calls the later patients were kept waiting for longer than I (or they) would have wished.

All this was long before QOF, but there would seem to be no reason why such a system could not work well, with an extra few minutes added on for those doctor-centred elements. Thus the patient would feel they had had a fair hearing, and the doctor would not feel pressured into trying to squeeze the QOF components into a 10-minute slot if the patient's agenda was a long one. After all, who tells the patient that the appointment is for 10 minutes? With this system, the patient knows exactly how long they've got. Also, the doctor would not have in the back of his or her mind the oft-quoted fear of the patient who brings a list, surgeries would not overrun, waiting rooms would not be full of disgruntled patients; the benefits would seem considerable on both 'sides'.

The obvious counter-argument is that surgeries would take longer, or that fewer patients would be seen. That was not the case when I tried it; Sampson's article makes no mention of this aspect; clearly more information is needed, but in the meantime, why not try it?

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The numbers needed to inform consent?

Is consent ever informed if the numbers that describe risk remain a mystery to most people? Better ways and numbers¹ to explain overall benefits and risks like numbers needed to benefit (NNB) and numbers needed to damage (NND) are welcome, but may fail to inform most decisions. Doctors often don't know the numbers needed to treat (NNT) and numbers needed to harm (NNH) or don't explain the true benefits and harms of tests and treatments. Patients usually consent with only a poor understanding of their risks.

Patients usually overestimate the benefit of treatments.² For example, many people using statins or antihypertensive's believe they are substantially reducing their risk of heart attack or stroke. Assuming that the treatment is safe and used for 5 years, only a few patients would take a drug if they thought that they had a 5% chance or less of benefiting (NNT 20). Half of the patients would take a drug if the chance of them benefiting was 20% (NNT 5). If the benefit was 5% or less then the number of patients willing to take a preventive drug was doubled if their doctor recommended the treatment. Most interventions are not that good.

Different doctors and patients cope with the same risk differently and the subsequent management of the same conditions varies widely.³

How can understanding of risk and consent become better informed?

GPs need to know and explain the frequency of benefits and harms of the tests and treatments that they recommend to patients. To be able to do this risk scores like NNT, NNH, NNB, NND for tests and treatments need to be easily

accessible to inform everyday decision making and GPs need to benchmark their own understanding and tolerance of risk and make this clear when they make recommendations to patients.

If patients can make sense of their risk they will make more informed and personal choices about their care (and may often decline care).

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Family medicine in Africa

Our fellow generalists have shown realism and honesty combined with academic rigour about the difficulties they face in establishing family medicine in Africa (except in South Africa). The tendency to hope that family medicine will fill the gap is understandable in a continent with such a huge shortage of healthcare workers¹ but it sounds as if family medicine in Africa is drifting into becoming a hospital-based specialty and its links with its 'spiritual home' in primary care are becoming severely stretched; as evidenced by the comments from Kenya.

*Now More than Ever*² promoted universal coverage, services based around peoples' needs and healthier communities, which are all best addressed in services outside hospitals. Starfield argues for better primary care services for economic³ as well as moral reasons⁴ and de Maeseneer, although strongly supportive of family medicine in Africa, argues consistently for increasing development of primary care provision, especially through the 15by2015 initiative.⁵ Finally the looming

increase in burden of disease due to non-communicable diseases, that by 2030 in low income countries is predicted to increase to over 50% of the overall burden,⁶ will be best dealt with in primary care. Thus my question is: 'does family medicine in Africa need to re-evaluate the direction it's being drawn into and consider placing itself more strategically in the community?'

Repositioning itself more obviously in the community may also help family medicine to be more distinctive and better understood by others (colleagues as well as patients). This is especially true for training, the goal being to achieve the aspirations as set out by Reid,⁷ that reach well beyond performing procedures in hospitals. UK generalists have decades of experience training outside hospitals and it may be an area for collaborative work. One possible way the NHS/RCGP could offer support would be to release (and financially protect) some appropriately experienced GP trainers to support carefully selected family medicine training programmes in Africa by providing a training component in the community as an alternative to hospital-based training; this is generally not happening at the moment: in some cases 35 out of 36 months training are in hospital.

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Frostbite developing secondary to cryotherapy for viral warts

A 15-year-old male was referred by his local accident and emergency (A&E) department with dark blistered lesions over the sole of his left foot and palms of both hands. Eight days prior he had received cryotherapy treatment for viral warts by his GP.

Two days after the initial procedure the patient requested an emergency appointment at his general practice because of intense pain over the treatment sites and feeling generally unwell. He was informed the pain was a normal side effect of the treatment and was likely to last no more than 10–14 days. Four days later the patient, with worsening pain and feeling unwell attended an out-of-hours GP. The treatment sites were noted to have progressed into substantially larger lesions compared to the initial size of the warts. He was told to arrange an appointment with his own GP the following day for further review and urgent referral to the trauma and orthopaedics team.

The following day, after review in A&E, he was referred to the wound clinic at the hospital for the following day. On attendance at this clinic, now some 8 days post-procedure, the examining doctor made an urgent referral to the burns and plastic department for advice about further management given the unusual appearance and size of the lesions. The patient attended our department the same day.

On examination, dark grey/black fluctuant blistered areas were noted over the head of the metatarsal of the left great toe as well as overlying the calcaneum. Similar lesions were seen over the palm, volar index finger, and volar thumb of his right hand and over the palm and volar thumb of his left hand (Figures 1, 2, and 3). The overlying skin was cold to touch and insensate. The necrotic skin overlying the initial cryotherapy sites were noted to be many times larger than the initial wart lesions, that were described by the patient as being 'tiny' compared to the blistered areas. A diagnosis of frostbite secondary to cryotherapy was made. The wounds consisting of necrotic skin (epidermis and