

socioeconomic status were more likely to have contacted their GP surgery than those of higher socioeconomic status hints at the possibility of life difficulties, coping skills, and educational attainment all influencing the need to consult in RTI.

On a more positive note, it is encouraging to learn that among the 14% of patients given a delayed prescription, a large minority (38%) did not collect them, confirming the usefulness of this strategy.

That 47% patients with RTIs consulted because their symptoms had not improved after several days confirms that patients often have unrealistic expectations about symptom or illness duration.² Patient education on this topic needs to be delivered effectively by GPs in their consultations, and in any public health campaign to reduce demand.

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In their NICE study on expectations for consultations and antibiotics for respiratory tract infection in primary care, the authors describe the point of view from the patients in an RTI clinical iceberg; the authors come to the conclusion that most who ask for antibiotics are prescribed them.¹

In the triade patient–doctor–society, from the point of view of the society, as mentioned by the authors, more and more countries do national public campaigns to promote appropriate use of antibiotics in the community.

Otherwise, from the point of view of the doctor, one can also ask questions about the ICE (Ideas, Concerns, Expectations) of

patients in general practice consultations, and their relation with medication prescribing. Now, do most patients expect antibiotics? Surely not.

In a study on ICE, an analysis of 350 new contacts showed that the expression/unveiling of expectations of patients ($P = 0.009$, OR = 2.0, 95% CI = 1.2 to 3.4) was associated with not prescribing new medication (dichotomised into the categories present/absent); in a subgroup analysis of respiratory complaints ($n = 90$), evidence was even found for fewer antibiotic prescriptions when two or three ICE components were present, compared to the group with no or only one ICE component, namely 6/36 versus 20/54 prescriptions of antibiotics ($P = 0.056$, OR = 0.34; 95% CI = 0.10 to 1.04).²

The conclusion of McNulty *et al.*, may give the impression that patients especially expect antibiotics and this is not the truth. As many patients who contact their GP surgery expect advice and reassurance rather than antibiotics, there is an opportunity for GP practices to give more advice about how patients may relieve symptoms. Systematically disclosing the patients' real expectations and concerns could lead to less unnecessary use of antibiotics.

There remains an important link between the stages of the ICEberg, namely how the GP deals with request of patients for antibiotics.

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Family medicine in the emergency department, Jordan

Increasing demands on health services have resulted in a number of innovations in delivering care. In November 2005, a unique new care model was started in the

emergency department (A&E) of Al-Bashir Hospital, the largest government hospital in Amman, Jordan. Family medicine physicians (specialists and residents) started working and are still working in newly added clinics to the A&E department, providing 24-hour primary care services to non-urgent patients; 'inappropriate attenders', on a non-appointment basis, with the aim of decreasing the pressure on the overburdened A&E department.¹

In 2006 the total number of patients was 99 286 (272/day) in 2007, 102 127 (280/day), and in 2008 total 143 186 (392/day), a 40% increase. In 2009 the number of patients continued to rise, reaching a maximum of 649/day during the month of May. In October 2009 a nominal fee was re-established, that led to a dramatic decrease in the number of patients, falling to 8126 (271/day) in November. By 2010 the total number was 111 962 (307/day), a 37.2% reduction from 2009. In 2011 the total was 116 862 (320/day).²

Research from several countries support the new role of family medicine physicians in the A&E department. Boeke *et al.*, in Amsterdam, the Netherlands, concluded that the new care method that combined the involvement of a GP in the A&E department and allocation of patients by triage to either the GP or the A&E physician, resulted in greater patient satisfaction and maintained the quality of care, with fewer additional examinations.³

Dale and his coworkers at King's College School of Medicine and Dentistry have been researching the demand for 'emergency' primary care since 1988. They concluded that employing GPs in the A&E departments to manage patients with primary care needs reduced rates of investigation, prescription, and referral when compared with hospital doctors.¹

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