We need another word for ‘chronic’

Is it time to stop using the word ‘chronic’ and talking about chronic disease? The BJGP in December has the reference to chronic in the title of four of its articles.1-4 Language changes with time and with usage. For example, the phrase ‘terminal care’ has made a transition to the more positive-sounding ‘palliative care’, not least because we are far more open in our discussions with patients than we were a generation or two ago and need to be sensitive to their interpretation of our terminology. Similarly, doctors may understand the term chronic in its primary dictionary sense of ‘persisting for a long time or constantly recurring’ and so may the some of the public.5 But others are more likely to hear its secondary, informal meaning ‘of a very poor quality’ and be offended, frightened, or bemused by this label being attached to their disease or, worse still, to their general health?

As we revise our curriculum at Nottingham we hope to incorporate further student experience that is community based with patients who have single morbidity or multiple comorbidities. Our debate is not over the urgent need for such education with population demographics changing to an increasingly older population, but what we call it, rather than chronic disease. Could it be: long-term conditions; integration of chronic non-malignant musculoskeletal pain; a qualitative systematic review.6

Primary care patients’ reasons for choosing emergency department services in Jordan

Over-use of emergency departments (EDs) by patients with primary care problems is a matter of concern. I studied patients and carers of children attending the family medicine clinics in the ED of Al-Bashir Hospital in Amman, Jordan1 from May to July 2011, during office hours (Sunday to Thursday, 8:00–16:00) to determine their main reason for choosing this service rather than a GP or medical centre.

A total of 1310 patients attended: 747 (57%) were adults, 563 (43%) were children accompanied by carers and 778 (59%) were female and 532 (41%) male. Reasons for attending were: 374 (29%) self-assessed urgency, 301 (23%) convenience (accessible and less waiting time), 231 (18%) self-assessed seriousness, 143 (11%) took treatment but still not well, 122 (9%) referred from other facilities, 97 (7%) needed a second opinion, and 42 (3%) were related to sick leave.

Siminski et al’s survey in Australia2 suggested three important reasons: urgency, being able to see the doctor and have tests or X-rays done in the same place, and the seriousness or complexity of the health problem.3 The EMPATH study in the US3 identified five factors characterising patient’s principal reasons for seeking ED care, with medical necessity the most frequent, followed by ED preference, convenience, affordability, and limitations of insurance.

There is an important distinction between clinically-assessed triage categories and self-assessed urgency and complexity. Patients can only be expected to act on their own judgement.4 Use of the ED is for most people an affirmative choice over other providers, rather than a last resort, and it is often a choice driven by lack of access or dissatisfaction with other providers.5

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DOI: 10.3399/bjgp14X677437

Self management: what happens to people with long-term conditions in between NHS appointments?

The NHS is grasping the nettle of activity promoting self-management as part of the long-term conditions (LTC) QIPP programme, but clinicians are slow to engage and consultations with individual patients are often few and far between. Is this really going to be enough to keep patients motivated to self-manage their condition? Less discussed, and even less understood is the role of voluntary and community organisations in promoting self-management. Organisations based in the community are well placed to engage, support, signpost and deliver activities to increase self-care, self-management, and levels of activation for people with LTCs.

The Think Ahead: Stroke Information Service in Wigan has developed a Self-
Improved support required to increase breastfeeding rates

Rosie Sayers'1 article is an interesting discussion on the impact of our wider culture on the acceptability of breastfeeding in public and suggests this as an important cause of low breastfeeding rates in the UK.

However, from my own personal and professional experience, I believe lack of effective support to overcome low confidence and common problems encountered when establishing breastfeeding (for example painful nipples and concerns about insufficient milk supply) is at the core of the issue.

According to UNICEF, 81% of UK mothers in 2010 initiated breastfeeding demonstrating that women are generally motivated to breastfeed, however, by 6 weeks only 17% were exclusively breastfeeding. Increasingly mothers are discharged from hospital shortly after giving birth and usually before breastfeeding has become established. While mothers routinely have two to three follow-up home visits from midwives and health visitors, they report that these encounters are often rushed due to over-stretched resources with little continuity and that they commonly receive conflicting information. Women with breastfeeding difficulties are directed to drop-in clinics or seek information from organisations such as the National Childbirth Trust (NCT) or Le Leche League.

This fragmentation of advice and follow-up can be overwhelming to new mothers and it is understandable why formula feeding is often seen as the most reliable option. A Cochrane review of breastfeeding support3 showed that, while all forms of extra support increased the length of time women continued to breastfeed, support that is only offered if women seek help themselves is unlikely to be effective, and suggested that predictable, scheduled, ongoing visits were key to extending the time that women breastfeed.

While the UK has made real progress in increasing rates of breastfeeding initiation, the focus of attention needs to shift to providing improved support to those mothers who want to continue doing so. In addition to the wider cultural factors highlighted in Rosie Sayers’ article, focusing on issues including the nature, frequency, and continuity of long-term support as well as availability of effective information is central to tackling low breastfeeding rates in the UK.

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