I enjoyed the article about how to combat urgent care pressures by improving collaboration between primary and secondary care physicians.

You state that educational days for GPs to spend time in the acute admission unit have been of mutual benefit. I am wondering whether you have considered a similar educational day for acute consultants to spend time in general practice. Perhaps this would provide insight into the reality of community care, promote a more positive relationship and encourage shared ideas about how cooperation can be improved.

The September 2013 Future Hospital Commission report from the Royal College of Physicians proposes improved integration of acute, general, internal, and community doctors. In time this should mean that community placements become a key part of core medical and medical registrar training; certainly acute medical placements already feature in the majority of general practice training programmes. Broad-based training programmes have also been implemented in several deaneries aiming to provide ‘specialist generalist’ doctors. Hopefully these attempts to gain a common understanding of our specialties will help to provide a more effective service to our patients.

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Five cards
The authors of the interesting Debate & Analysis article mention that the application of five cards might show — verbally and non-verbally — that the doctor has recognised and understands what he has heard: when the three patient’s cards of Ideas, Concerns, and Expectations (ICE) have been played, the doctor may have a better understanding of the patient’s illness experience; and the two other Receipt and Summary cards seem to be a response as a receipt in confirmation.

Although the application of the aforementioned ‘cards’ seems justified, and most of us have the impression that the ICE acronym works, until now there is a scarcity of studies on ICE: there are no (efficacy) randomised trials on ICE and no patient satisfaction studies on this acronym. As far as we know there is only one cross-sectional study with students in educational training which showed that the mean number of ICE components per doctor and per contact was 1.54 (SD 0.54); one, two, or three of the ICE components per doctor and per contact was 38.5%, 24.4%, and 20.1% of contacts, respectively. On the other hand, in 22% (77 out of 350) of the new contact reasons, no ICE was voiced, and the GPs operated without knowing this information about the patients.

In our contact with students and their video consultations of patients, we perceive some recurring facts:

- Students are ‘conditioned’ and tempted to concentrate on the detail of the symptoms instead of what the presenting problem means for the patient with its current and future implications. They find it sometimes difficult to explore the ICE components and to clarify and play all (unexpressed) ICE cards; because expectations are often difficult to explore for students, we suggest alternatives for example: ‘Mr X, you expect an X-ray or you want medication now?’; or ‘What do you prefer: a painkiller or had you thought of a-style of medication now?’

Author’s response
Thank you for your challenging letter and for the opportunity for us to comment.

Having looked at video consultations from both experienced doctors and medical students over the past 25 years I have seen the recurring pattern of interrupting the patient’s story due to perceived time pressure, powerlessness, and the urge to test hypotheses. It turns out to be so difficult for the doctor to explore the world of the patient before entering the familiar world of medicine.

To understand why the patient is here and to feel a natural empathy, I need to know his ICE. The two cards, Receipt and Summary are effective tools for introducing the ICE questions and not asking for symptoms and test hypotheses. Then the doctor can stay in the patient’s part until the patient has finished his prepared story and is ready to listen. Rather than looking at ICE and the cards as something we have to do for the user — one of the authors of the interesting Debate & Analysis article, Helen Pidduck, has some insights on how to improve collaboration between primary and secondary care physicians. She suggests an educational day for acute consultants to spend time in general practice, which could provide insights into the reality of community care and encourage collaboration. She mentions the September 2013 Future Hospital Commission report from the Royal College of Physicians, which proposes improved integration of acute, general, internal, and community doctors. However, there is a scarcity of studies on the ICE acronym, with only one cross-sectional study with students in educational training. The authors of the article also mention some recurring facts in their contact with students and their video consultations of patients. They suggest alternatives for students, such as asking what the patient expects or prefers. The author of the response encourages doctors to understand the patient’s story and to feel empathy, which can be achieved by asking ICE questions and not just asking for symptoms and test hypotheses. Instead of interrupting the patient’s story due to perceived time pressure, the doctor should concentrate on understanding the patient’s illness experience and their expectations. The response highlights the importance of improving communication skills and collaboration between different specialists in healthcare.