All letters are subject to editing and may be shortened. General letters can be sent to bjgpdisc@rcgp.org.uk (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication. For submission instructions visit: <http://www.bjgp.org/letters>

Editor's choice

The article in the *BJGP* June edition advised that people with bleeding varicose veins should be referred immediately. Might I suggest elevation and compression is the initial management. This may seem obvious but there will be the risks of this article being taken at face value. It also recommends referring superficial vein thrombosis. Is this the new name for thrombo-phlebitis? If so may I suggest one needs to rule out underlying DVT (superficial thrombosis may lead to a rise in D-dimer) and check for signs of underlying malignancy. Also recommended is referring any venous ulcer that has not healed within 2 weeks. Have the authors ever seen a venous ulcer that does heal within 2 weeks? We are being encouraged to reduce unnecessary referrals.

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DOI: 10.3399/bjgp14X680821

Effect of Ramadan fasting on emergency walk-in-clinics in Jordan

Ramadan is the month of fasting for Muslims; they fast from dawn to sunset. I studied patients attending walk-in-clinics in the emergency department of Al-Bashir Hospital¹ during the month of Ramadan 2010, 11 August to 9 September. A total of 7770 patients attended: 2566 (33%) attended in shift A, 8:00–18:00 hours (divided in two sessions), 2124 (27%) in shift B, 18:00–23:00 hours, and 3080 (40%) in shift C, 23:00–8:00 hours. There were 4198

(54%) males and 3572 (46%) females, with a male:female ratio of 1.17:1. There were 1951 (25%) patients aged 1–5 years and 6458 (83%) aged 1–40 years. Patients of <1 year old are admitted directly to the paediatric emergency room. The main presenting complaint was upper respiratory tract infection in 1889 patients (24%), followed by acute simple gastroenteritis in 1313 (17%), abdominal pain in 726 (9%), skin problems in 456 (6%), renal problems (urinary tract infection and renal colic) in 443 (6%), and 224 (3%) requesting sick leave. A total of 724 (9%) were referred back to on-call teams. In Ramadan, young patients with upper respiratory problems were the main attendees, and shift C was the busiest.

I was able to compare these figures with observations made in the same clinic over a 1-month period earlier in the year (18 April to 17 May 2010), during which time 10 000 patients consulted. The age and sex distribution of attendees during Ramadan was similar to this period, but the proportion of patients attending during shifts B and C was almost reversed: 27% and 40% respectively during Ramadan compared with 43% and 24% during the earlier observation period. The main reasons for attendance were also similar in both cohorts.

These findings are surprisingly similar to data collected in the UK. Salisbury and Munro's review article in 2002,² concluded that young patients with minor problems, mainly upper respiratory symptoms, were the main attendees for walk-in-centres. Dale and co-workers³ at King's College School of Medicine and Dentistry concluded that young patients with minor problems were also the main characteristics of primary care patients attending the emergency department. However, the constraints of Ramadan appear to modify the timing of the presentation of these problems, but not their frequency.

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DOI: 10.3399/bjgp14X680833

Access, continuity, or both

The Royal College of General Practitioners seems to wish to promote continuity over accessibility.¹ However, continuity and access are not mutually exclusive. Sometimes patients or parents have to make a trade-off between speed of appointment and choice of doctor. Those with a new problem, children, and those who work, prefer speed. Those with long-standing physical illness, women, and older people, prefer their own doctor. In any case, establishing and maintaining a relationship with a clinician depends on having ready access to them.

There is only equivocal evidence on the relationship between continuity and patient outcomes.² Seeing the same doctor does not guarantee a good relationship! Dr Harold Shipman is a well-known example of how things can go very wrong. Indeed a particular risk of continuity is of collusion, for example in sickness certification or of perpetuating pathological behaviours.³ On balance, the benefits of relationship continuity appear to be better supported by research than the risks. On the other hand, generally speaking, practices that perform well on delivering a good experience for their patients also perform well on measures of clinical quality.⁴ Better access consistently showed the strongest link with the process and outcome indicators of quality.

One study found that better access to primary care was correlated with higher QOF scores, and lower rates of emergency admission,⁵ and another with lower emergency department utilisation.⁶ Another study found delayed first diagnosis of cancer⁷ with poor access.

The debate should no longer be about either access or continuity, but how both are delivered. This will involve investment in

primary care capacity and capability, as we have done in Central Manchester.

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DOI: 10.3399/bjgp14X680845

Access to general practice and A&E attendance

Cowling *et al* have added a useful piece of work to the increasing understanding of acute care and the interface between general practice and accident and emergency (A&E) in England.¹ In the absence of good quality data from A&E departments this was a creative use of primary care data to estimate impact of patient access to healthcare services.

However, focus on availability of GP appointments only addresses a sub-section of patients who attend A&E departments. While patients often cite poor availability of GP appointments as a reason for attending A&E, a significant proportion have already seen a GP or not tried to get an appointment. One recent survey of patients with minor ailments found that 32% of A&E attenders had not tried to make a GP appointment and a further 10% came for a second

opinion following GP consultation.²

While the increasing strain on general practice will inevitably force more patients into emergency departments we need to recognise that many patients choose A&E in the first instance. Perhaps it is time to accept that patients with minor ailments are as likely to attend an A&E department as see their own GP. Planning resources and standardising training in management of minor ailments across general practice and emergency medicine may do more than the political drive to open GP practices for a few extra hours a day.

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DOI: 10.3399/bjgp14X680857

Patients are often unaware of how to access medical help out of hours

Out of hours' (OOH) care is currently under close scrutiny. In order to understand patients' perspectives on OOH care I conducted a survey of 186 sequential patients (87 men and 99 women aged 17–93 years) in a rural practice in central Cornwall with a patient population of 5011. Those <16 years, temporary residents, and those with significant cognitive impairment were excluded. Patients were asked 'Do you know how to reach medical advice out of hours?'. If the answer was 'no' they were invited to make a guess to see if they would reach the right conclusion.

Almost half (44%) knew how to obtain medical advice out of hours and a further 17% guessed correctly, but 33% made an incorrect guess or no guess at all, and the remainder made an alternative suggestion which was likely to be successful. Dialling

999 was suggested by 9%. The incorrect attempts at 111 were surprisingly varied and included 101, 118, 121, 212, 911, and 991. Small numbers of responders would ask a relative or go to accident and emergency.

The study is small but hints at a significant problem, because one-third of the sample was unaware of how to access appropriate OOH care. This group represents patients who are either making demands on the ambulance service instead, or are missing the opportunity to access suitable OOH care.

Better awareness could be achieved by an information push within practices and commissioning groups, and possibly the use of patient participation groups. Making the future NHS work on budget will need collaboration between medical professions and the public; improved systems and communication should be a cornerstone of this work.

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DOI: 10.3399/bjgp14X680869

A simple clinical coding strategy to improve recording of child maltreatment concerns: an audit study

Recording concerns about child maltreatment, including minor concerns, is recommended by the General Medical Council (GMC)¹ and National Institute for health and Care Excellence (NICE)² but there is evidence of substantial under-recording.^{3,4} GPs are apprehensive about how recording is perceived by parents and the impact of this on the patient-doctor relationship.⁴ However, careful clinical coding, even of minor concerns, is essential for building a cumulative picture of concerns and making children 'findable' on the system.

We determined whether a simple coding strategy (www.clininf.eu/maltreatment) improved recording of maltreatment-related concerns in electronic primary