Beyond the consultation room: GPs and physical activity

We read last month’s editorial on promoting physical activity with pleasure, but feel the authors should have gone further.1 If we discovered a drug that reduced the risk of cardiovascular disease, diabetes, and cancer by 20–50%, calls for more education and signposting would be seen as risible. Treating physical activity seriously is good for patients and has the potential to significantly reduce GP workload.

Lifestyle behaviours like smoking, drinking, eating too much, and moving too little cause around 40% of deaths in the UK; yet we spend a relatively small amount of time combating these major drivers of disease with patients. In our surgeries we should ensure that we have bike stands, good public transport connections, standing desks, and adverts for local physical activity opportunities such as walking groups, exercise classes, and sports. We should support our staff in stopping smoking and maintaining a healthy weight by encouraging subsidised physical activity opportunities for NHS employees and access to cessation services.

Beyond the practice car park there are a myriad of ways that GPs can make a real difference to our communities by influencing the physical, social, and policy environments. We should be politically engaged: lobbying councils for green space, safe streets, cycle lanes, improved pavement surfaces, investment in public transport, accessible and affordable facilities for physical activity (including new free-to-access activities such as outdoor gyms), organised sports and community events, and accessible and affordable fruit and vegetables.

We have a clear mandate to engage in community-oriented health promotion,2 but currently there are no incentives, no time, and no training. Virchow said, ‘If medicine is to fulfill her great task, then she must enter the political and social life.’3 Promoting physical activity in our local communities demands this approach, and has the potential to reduce workload, prevent disease, and ultimately save lives.

REFERENCE

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Antibiotic eye drops for conjunctivitis in infants at nursery

The pressure to prescribe also exists in community pharmacy. In Scotland the minor ailments scheme, which is available to children registered to a GP practice, provides the opportunity for community pharmacies to supply antibiotic eye drops directly to parents at no cost to them. A patient group direction for chloramphenicol eye drops also allows this supply outwith the product licensing for the over-the-counter version of chloramphenicol eye drops; allowing the supply of generic chloramphenicol eye drops to infants.

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REFERENCE

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While locuming on Saturdays I have often supplied chloramphenicol eye drops to parents because of nursery policies that allow infants to attend nursery if they are being 'treated'.1 I do this knowing that the underlying cause of the infection is likely to be viral, which I feel uneasy about as it goes against my pledge to good antibiotic stewardship.

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REFERENCE

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Prevention of hospital-acquired thrombosis

Perhaps the BJGP should have a moratorium on papers which state that, ‘GPs are ideally placed to …’? Yes, I’m sure you can find someone to say we’re great at everything in medicine and beyond. But that doesn’t mean it’s our job or that we are actually the best people for it.

I’m pleased to report that in our area there is no uncertainty on this issue: hospital staff, who are actually ideally placed to assess and treat hospital-acquired thrombosis, do it.1 Surprisingly, there is no uncertainty on this issue: hospital staff, who are actually ideally placed to assess and treat hospital-acquired thrombosis, do it.1

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Improving access to primary care: can online communities contribute?

Roger Jones’s editorial1 described primary care in the context of accessibility, effectiveness, and care that is provided personally, and concluded that creative solutions are needed. More than 15 million people in England have a long-term condition or disability for which there is no cure, and these people account for at least 50% of all GP appointments.2 Peer support is a self-management activity3 with the potential to improve self-care while reducing demand for primary care appointments. Work on an online community of patients with stroke revealed that up to 95% of information and support requests were answered on an individual basis.4 Responses received by peers were accurate and appropriate. At a time when GP surgeries are working at and beyond capacity, and patients are finding it difficult to obtain appointments, these online forums can provide a way for stroke survivors and their carers to receive helpful advice and support. As the NHS has been challenged to develop and benefit from digital health, primary care research should explore online patients’ communities as potential self-management interventions. Such interventions could take up part of the service demand for information and indirectly improve access to primary care.

The use of online peer support within the NHS will be driven by providing research evidence that it is a cost-effective way of improving patient health and welfare. Outstanding questions to be answered include:

• How do effective online patients’ communities form and maintain over time?
• What are suitable outcome measures for measuring effectiveness and cost-effectiveness of online peer-to-peer self-management?
• What part of healthcare demand can be safely dealt with by online patients’ communities?
• How can online patients’ communities be effectively policed to protect individuals from online risks?

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