Letters

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Editor's choice

Keep examining patients

I would heartily endorse Rose Brettell's[1] and Crispin Fisher's[2] view that careful physical examination of patients should be paramount and particularly in the isolated setting of the GP's consulting room far away from pathology labs and 'hi-tech' investigative machines.

But I feel one reason has not been sufficiently emphasised. Patients expect to be examined, respect it, and are reassured by it. When the doctor lays his hands on the areas of the body whose symptoms suggest are diseased the doctor builds a tactile bridge to the patient with which no amount of talking can equate. My grandson, following years of suffering severe childhood eczema, travelled over 200 miles to see a consultant dermatologist who never even looked at his skin!

I have friends with chronic back pain who have never had their backs examined! Keith Hodgkin, a distinguished GP guru of the sixties and seventies, maintained that, *'Once you've done a rectal examination the patient will tell you everything!'*

Perhaps two kinds of doctors are emerging: the 'hi-tech' doctor in the hospital who uses machines to diagnose and the GP in their consulting room who uses their five senses plus a few simple instruments to achieve the same end — and incidentally much more quickly and certainly less expensively.

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Hearing crackles: why all GPs should pass PACES

Crispin Fisher's enjoyable letter[1] brought to mind an experience I had as a teaching GP on a cold morning's surgery.

First of all I saw a male in his 50s with flu-like symptoms and high temperature. Auscultation of his chest disclosed bilateral crepitations in most areas. I let my trainee and student listen to his chest. I decided he needed to go to hospital. While waiting for the admissions officer at the local hospital, the three of us discussed possible diagnoses and management. The patient was duly admitted. I was very satisfied, especially having been observed by a trainee and medical student. Later that morning I saw a patient in his 30s with a cough. To my surprise he also had crepitations on the base of one side only. He was a smoker. I sent him for a chest X-ray at the local chest clinic.

Later that day, I phoned the hospital to check on my patient. The registrar told me the patient had only a minor chest infection. The X-ray was clear and he had been sent home with antibiotics. I then phoned the chest clinic and found that the second patient's X-ray was also clear. I was very surprised. Fortunately, neither the trainee nor medical student was with me, so I escaped embarrassment. I wondered what might have gone wrong. A careful examination of my stethoscope revealed a hairline crack on the plastic tube on the right side, just below the attachment with the metal. This crack became wider when I moved the stethoscope from side to side, but did not open much in the upright hanging position. I never used it again. It is still with me as a piece in my personal museum. I revealed the truth to my trainee and the medical student the following day and they both saw the funny side. We are, after all, only human.

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Response to a news article on the RCGP website

I have read with great interest both the news article published on the RCGP website, 'Thousands of GP appointments "lost" due to children with conjunctivitis being turned away from nursery, says RCGP',[1] and the leaflet produced by the RCGP to educate childcare professionals, parents, and teachers about managing conjunctivitis in young children.[2] General practice is under unprecedented workload pressure,[3] and every attempt to rationalise appointments so that resources can be utilised appropriately ought to be commended.

The purpose of the aforementioned leaflet is to reassure parents *et al* that young children with conjunctivitis do not require assessment by a GP, nor exclusion from school. I wonder, however, that in emphasising this message, if the RCGP has oversimplified the advice regarding the use of antibiotics. The leaflet states that children 'DON'T need to ... use antibiotics'. A literal interpretation of this particular language by parents *et al* may lead to children with severe conjunctivitis not receiving treatment and risking serious complications. This advice is not in keeping with a National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary (CKS),[4] which, having based its recommendations on a recent Cochrane Database Systematic Review,[5] concludes that topical antibiotic treatment should be administered in severe cases.

The NICE CKS accepts that there is no agreed definition of severe conjunctivitis, and that it is reasonable to use clinical experience to determine the severity of a case. Perhaps a revised version of the leaflet, one that applies specialist ophthalmology input to highlight the difference between

severe and non-severe conjunctivitis, would be more effective in triaging those children in need of antibiotics towards a GP, while simultaneously meeting the RCGP's objective of rationalising appointments.

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Bad medicine: resilience

A genuinely poignant and insightful critique of the resilience paradigm that deserves much wider scrutiny.[1] 'Vulnerable' practices are portrayed in our present NHS as outliers, dysfunctional and lacking in this apparently discrete and tangible construct of resilience. In reality, appraisers will observe that ALL practices are vulnerable in the present climate and that the insinuation that professionals struggling against a tide of politically orchestrated adversity are in some way 'lacking' is both deeply flawed and distasteful. It was fascinating to reflect upon the author's analysis of the tide of health anxiety/systemic unhappiness that is sweeping our consulting rooms. Time to recognise the remarkable gift that most primary care teams bestow every single day in the face of hypocrisy. Unless our profession owns self-worth, we cannot hope to develop a meaningful *détente*. Our profession's laudable functional malleability must not be mistaken for ideological nihilism.

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We all think we're going to die

If a plane should crash and the passengers all survive, some of them will tell you that when they got on the plane they 'knew' it was going to crash and the media will portray them as clairvoyants. What they probably won't consider is that every time a plane takes off, a few nervous passengers are thinking that it might crash (while they wash down a valium with a gin and tonic).

Every day I see three or four patients whose gut feeling tells them that their symptoms are due to cancer.[1] I see three of four new cases of cancer a year. One or two of those who have cancer might have suspected cancer when their symptoms began, and were eventually proved right. Often people are diagnosed with cancer who weren't suspecting it at all.

Of course we should listen to patients' concerns, interpretations, fears, and so on. And of course we could do better. But if we are to be clinicians, then we need to put what we hear into context and use our clinical judgement.

If we overstate the importance of gut feeling, we will refer unnecessarily, wasting patient and clinician time, and money. And those whose guts are less feeling, but do have cancer, will suffer.

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Correction

In the November 2016 article by Juan Brañuelas Quiroga, *et al.* Hiccups: a common problem with some unusual causes and cures. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687913, the captions for Figures 2 and 3 were transposed. This has been corrected in the online version.

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