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## Editor's choice

### What advice should we give to patients about their consultation?

In 'Tips to help your GP', the focus is on helping the patient to help the GP.<sup>1</sup> Although this is obviously important, the patient is the person who should come first. Being a GP must be incredibly stressful. Undoubtedly there are things that patients do that make the job harder. But patients are often nervous, may have had bad experiences, and may be very poorly. I think it is important to be as positive and helpful as possible, rather than giving them reasons to feel worse.

Your poster has no introduction and seems critical towards the patient reading it. Parts feel very patronising, such as the points that focus on 'behaviour and attitude' in the consultation, telling people to cover their mouths when coughing, to 'dress appropriately', and to make sure they have washed. Many patients would love your suggestion about continuity of care, but then they would often be unable to see someone for several weeks. Booking with the 'correct professional' is ideal but it is not always obvious who this is.

It would be more helpful and positive to have 'Tips to help your GP help you' and to help the patient ask appropriate questions such as those suggested here: <https://www.nhs.uk/nhsengland/aboutnhservices/doctors/pages/questions-to-ask-the-doctor.aspx>.

I wonder if you asked patients about what would help them during a consultation? Health care should be a partnership, with GPs who are the experts by training, working together with patients, who are the experts by experience.

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## Scholarship-based medicine

Few *BJGP* readers will disagree with Professor Reeve that '[w]e need whole-person, generalist medicine'.<sup>1</sup> But I feel that Reeve uses an overly narrow conception of evidence-based medicine (EBM) to justify throwing the baby out with the bathwater. By omitting to reference the growing literature that critiques EBM, this article sets up a straw man, ignoring the well-established move to focus on evidence-based practice. This move challenges the old 'knowledge pipeline' model, in which clinicians simply received 'proven facts' and used them, and patients relied on clinicians to hand over these facts. Instead, we need to understand the way both clinicians and patients construct knowledge and use it in making decisions together.

I agree with Reeve that this understanding requires a more nuanced model than the version of EBM she portrays. But rather than replacing this old (and increasingly discredited) model with a new one that emphasises the distinction between 'specialist' and 'generalist' practice, I suggest it will be more helpful to build on Greenhalgh *et al's* call for a new 'real EBM',<sup>2</sup> highlighting the central challenge that all clinicians face: how to use probabilistic information about a population to shape decisions about one individual. Like generalists, specialists should use this information within a holistic, person-centred approach that requires wisdom as well as 'science', although we all struggle to achieve this. As a GP, I cannot achieve it in 10 minutes, however much I 're-prioritise'. Before trying to devise a way to evaluate my 'capacity to deliver person-centred care', why not fund me to offer patients a bit more time and continuity, and then check that I am providing it?

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## Scholarship-based medicine and retirement of EBM

Reeve's article does not address several issues, which simultaneously make the approach under-ambitious and have divisive, probably unintended, consequences.<sup>1</sup>

First, are there specialists and generalists? Many 'specialists' practise in 'generalist' mode within their discipline, and GPs with a special interest contribute to secondary care.<sup>2</sup> The division suggested by Reeve would not incorporate these colleagues who would presumably utilise different philosophical models in different roles. It seems unlikely that these are the only models to answer clinical questions and that there is no spectrum between these approaches. For example, psychiatrists take a biopsychosocial approach to formulating a patient's diagnosis and management.<sup>3</sup>

Scholarship-based medicine does not recognise that different approaches are needed at different times. The generalist will likely follow protocol in an emergency resuscitation situation; specialists may need to make a diagnostic decision, then consider the appropriateness of major life-changing treatment incorporating a wide range of factors.

However, our major concern is the implicit criticism that specialists do not consider the whole patient. This type of 'bashing' has been the subject of academic debate and widespread campaigns by royal colleges with the aim of improving recruitment.<sup>4</sup> Such division is unhelpful to all.

The Chief Medical Officer for Scotland's realistic medicine strategy<sup>5</sup> suggests that patients ask these questions to make the right decisions about care; is this test, treatment, or procedure really needed? What are the potential benefits and risks? What are the possible side effects? Are there simpler, safer, or alternative

treatment options? What would happen if I did nothing? Perhaps if patients did ask such questions, or specialists and generalists did, a more scholarship-based medicine approach would follow.

Reeve thus develops a model, which, if it is to be truly effective for patients, should not just be the preserve of the generalist, but of doctors. A more ambitious approach may be not to redefine generalism, but remove criticism of others (not typical of GPs), and ensure that the prospect of generalist-led medicine is made more realistic.

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## A complex consultation

It was interesting to read Clare Gerada's editorial 'Doctors and suicide'.<sup>1</sup> The majority of doctors manage their health alone for several reasons: neglectfulness or denial, self-prescribing, the desire to present a picture of good health to others,<sup>2</sup> fear of causing their colleagues difficulty,<sup>3</sup> or fear that medical confidentiality will not be respected.

Questions on intimate subjects such as sexuality or addictive behaviours are rarely approached, or not at all.<sup>4</sup> This is also true of clinical examination,<sup>4</sup> often because the question of knowledge or hierarchy between the treating doctor and the doctor-patient comes into play.

We carried out a survey of 375 GPs who treated doctor-patients, using an online self-administered questionnaire based on elements identified in the literature as likely to affect management. The three main barriers to the relationship between treating doctors and doctor-patients from the perspective of the treating doctors were the difficulty in making the doctor-patient accept the patient role, the fear of error and of being judged, and competency in another specialty. The three facilitators were confidence shown by the doctor-patient, an equal level of medical competency, and the relaxed atmosphere of the consultation.

Medical management of doctors is a problem that is common to all countries, and one on which there is currently no helpful consensus. According to the British Medical Association,<sup>5</sup> a doctor-patient must be treated just like any other patient. The creation of dedicated health services would seem also to be a possibility. Canada and Spain are leaders in this field. A joint European initiative has been set up through the European Association for Health Physicians (<http://www.eaph.eu/>) and shows the need for research to aim for optimised and coordinated management.

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DOI: <https://doi.org/10.3399/bjgp18X699017>

## Corrections

In the Online First article by Smith SG *et al.* Prescribing tamoxifen in primary care for the prevention of breast cancer: a national online survey of GPs' attitudes. *Br J Gen Pract* 2017; DOI: <https://doi.org/10.3399/bjgp17X689377>, the author Andrea DeCensi was incorrectly listed as Andrea de Censi. The online version has been corrected.

DOI: <https://doi.org/10.3399/bjgp18X699029>

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In the article by Mordecai L *et al.* Patterns of regional variation of opioid prescribing in primary care in England: a retrospective observational study, *Br J Gen Pract* 2018; DOI: [10.3399/bjgp18X695057](https://doi.org/10.3399/bjgp18X695057), the Figure 2 caption incorrectly stated: 'Total opioids prescribed in equivalent mg morphine per capita per month from August 2010 to February 2014 ( $r = 0.48$ ,  $r^2 = 0.23$ )' but should have stated 'Total opioids prescribed in equivalent grams of morphine in England per month from August 2010 to February 2014 ( $r = 0.48$ ,  $r^2 = 0.23$ )'; additionally the y-axis of the figure incorrectly stated 'Opiate total in equivalent mg morphine per capita per month', but should have been 'Total equivalent grams of morphine prescribed nationally' with the axis label 'Months'. The online version has been corrected.

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