Letters

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Editor's choice

Consultation length matters

Euan Lawson is right to draw our attention to the length of the GP consultation in the UK.[1] Reference to martyrdom is not required. GPs and their practices have it within their gift to make the changes required to move from 10- to 15-minute consultations. We have recently done so at our own practice, and it would be fair to say that it has been the single most beneficial change in my 21 years at the practice. There has been a reduction in GP stress and anxiety (running late suits no one), morale has improved correspondingly, and patients are now given more time for their problems. We calculated that we would lose about 70 GP appointments across the week to achieve the change. In preparation for the move, these have been more than replaced by employment of nurse practitioners, a paramedic, a musculoskeletal FCP, and, most recently, a mental health nurse FCP.

Many practices are moving to 15-minute appointments, and we would urge others to plan to so do. We may even find it adds a few more precious years to GP careers.

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REFERENCE

1. Lawson E. Debrief: Consultation length matters *Br J Gen Pract* 2019; DOI: https://doi.org/10.3399/bjgp19X702473.

DOI: https://doi.org/10.3399/bjgp19X704213

We need a clear vision for primary care

Euan Lawson argues that we could lengthen our consultation times.[1] Changing surgery times would destabilise practices already on the knife edge. Our partnership model developed in the 1960s and was still working well in the 1980s. Then, maybe we did see or speak to around 30 people a day, now suggested as a safe limit by the recent *Pulse* workload study.[2]

Young doctors won't commit to joining partnerships, where the capitation model compels doctors to process 40–60 appointments per day with a further punishing hundred or so clinical decisions to be made in letters, messages, or results. Yet senior GPs can't let go of it, with cost-rent, CCG money, and out-of-hours businesses paying their school fees and their pensions.

There is a danger that vested interest is holding us back. General practice is evidently broken, yet we flounder, debating continuity and telephone triage. We need a firm, shared vision for primary care that includes what a reasonable workload is, safe for us and for patients.

We need to be part of an organisation large enough not just to employ a multitude of colleagues — sub-specialist GPs, specialist nurses, extended-role practitioners, diagnostic physiotherapists, call handlers, pharmacologists (and more) — but also to train us. It will research and implement the structures able to assign the right person for each task. Our future organisations will be large enough to mesh with out-of-hours services. Appointments will be accessible. Our reformed service will regain first-world cancer outcomes and reverse deteriorating life expectancy.

Taking primary care into the future requires the College to rise above the vested interests of its officers. It needs to set standards for doctors in primary care that may not be achievable in partnerships existing today. With this model behind us, and a clear College ruling on what is a safe workload for one doctor in one day, we could confidently take to the streets. Ending 10-minute consultations with a new approach to primary care will enable us to offer something approaching excellence once again.

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REFERENCES

1. Lawson E. Debrief: Consultation length matters *Br J Gen Pract* 2019; DOI: https://doi.org/10.3399/bjgp19X702473.
2. Howarth J. Workload survey: 'We are working beyond the safe level'. *Pulse* 2019; **8 May:** http://www.pulsetoday.co.uk/news/hot-topics/pulses-gp-workload-survey/workload-survey-we-are-working-beyond-the-safe-level/20038667.article (accessed 12 Jun 2019).

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Doctors' ongoing education, empathy, and continuous emotional and psychological support for patients might help to deal with their medically unexplained symptoms

I very much appreciate the article about medically unexplained symptoms (MUS), as MUS is a very important disease entity. An ongoing doctor–patient relationship is the key to a satisfactory outcome of managing patients with MUS. We have to acknowledge the patient's symptoms and suffering by addressing their wishes of explaining their symptoms arising from their expressed physical and psychosocial concerns, giving continuing emotional support and empathy. Doctors should not make the situation worse, by stressing the fact that there is no serious underlying disease, or implying the fact that the patient is putting on or imagining their symptoms.[1]

We always have to have an open ear to new symptoms and review the diagnosis, as 10% of symptoms thought initially to be MUS turn out to be an organic disease, and patients with MUS can develop additional serious underlying diseases over time. Continuously reflecting on altering symptoms, avoiding diagnostic anchoring, and providing safety netting will help us not to overlook red-flag symptoms of possible serious underlying diseases.[2]

Educating doctors and medical students is paramount in addressing their anxiety, frustration, and self-perceived lack of competency in MUS. Further research will show us the best way to acquire the clinical receptivity and practical skills to care better for our MUS patients in the future.[3]

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REFERENCES

1. Stone J, Wojcik W, Durrance D, *et al.* What should we say to patients with symptoms unexplained by disease? The 'number needed to offend'. *BMJ* 2002; **325(7378):** 1449–1450.

2. Burton C, ed. *ABC of medically unexplained symptoms.* Chichester: John Wiley & Sons Ltd, 2013.

3. Friedberg F, Sohl SJ, Halperin PJ. Teaching medical students about medically unexplained illnesses: a preliminary study. *Med Teach* 2008; **30(6):** 618–621.

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Who should pay for reviewing the ECGs from the Apple Watch 4 series?

The UK National Screening Committee has not recommended systematic population screening for atrial fibrillation. But, for those who can afford it, access to ECG screening for atrial fibrillation has already become a reality with the ECG app on the Apple Watch 4 series.

As a GP trainee, I have already seen two patients presenting with Apple Watch ECG tracings. But with no national screening programme in place, who should be responsible for the cost of reviewing these ECGs? And with ever increasing access to affordable home monitoring devices for blood sugar, fetal Dopplers, and private health checks, it seems likely that GPs will be managing an increasing volume of consultations related to false-positives generated by the private sector. Do we need to develop a system for managing the cost of the false-positives generated from private sector work as well as managing consumers' expectations of the benefits of unvalidated screening?

Perhaps as a bare minimum we need to develop an understanding of the burden of cost that the increasing level of private and home screening is putting on primary care, as well as how much value it may be adding.

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Checking our medical privilege

Euan Lawson has introduced a new concept to me: *'We all live in filter bubbles.'*[1] This was apparently first suggested by Eli Pariser in 2011. It is probably something that we may have thought of, but never given a name. We are the product of our experiences and view life from a personal perspective. Filter bubbles take this a bit further and it would seem we are driven deeper into our own bubbles by social media algorithms that protect us from dissenting opinions and come up with suggestions for what we like or crave. Our views become polarised and limited. The challenge is how to keep an open mind and be amenable to change or considering other people's views and opinions. I do find stances that leave no room for manoeuvre or even u-turns short-sighted and doomed to failure. The more you find out about something or someone, the more likely it is not black and white. The key skill to have is curiosity.

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REFERENCE

1. Lawson E. Debrief: Checking our medical privilege. *Br J Gen Pract* 2019; DOI: https://doi.org/10.3399/bjgp19X703829.

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How do you justify GMC fees?

GP numbers are in decline. I am a GPST3 Educational Scholar approaching the end of my specialty training. I have to pay £430 to the GMC for CCT in addition to the annual £150 for a licence. Spending £399 to be a member of the College and £1775 for the privilege of sitting the MRCGP equates to £2754 out of my salary for completion of the year.

We know how the College spends its income from fees etc., but can someone in the GMC who may be reading this explain why £430 is needed to complete this process at a time when the government should be trying to recruit, retain, and encourage us to get onto the register?

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Correction

In the Editorial by Chew-Graham CA *et al*, Medically unexplained symptoms: continuing challenges for primary care. *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X689473, the second paragraph stated: *'The annual NHS cost for MUS in adults of working age in England was estimated to be £2.89 billion in 2008/2009 (11% of total NHS spend)'.* This should have stated: *'The annual NHS cost for MUS in adults of working age in England was estimated to be £2.89 billion in 2008/2009 (approximately 10% of total NHS expenditure on these services for the working age population)'.* The online version has been corrected.

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