

Video consulting study

This excellent study recognises the growing interest in using video consultation with specific patient cohorts and in specific circumstances.¹ It can be a change for the good, but only if done for the right reasons. The technology needs to evolve, although there are some caveats about the experience described above. Notably, many practices are seeing the benefits of combining telephony and video traffic using the same 'pipe', avoiding the need for Wi-Fi upgrades. For others, the arrival of HSCN removes the old N3 connectivity issues. Video can now be played directly into modern browsers, reducing the need for additional downloads.

GPs should be able to switch between phone and video consultation quickly and easily, via their phone, laptop, or other mobile devices, and do so in a way that is familiar to the patient. Resultant conversations should be associated with the patient's record to inform clinical and administrative decision making. Connectivity should not be a barrier to efficient communication.

Many practices are recognising that this is not about choosing one form of communication over another; it is about choosing the right form of communication at the time. Phone, video, and face-to-face consultations can work together, if the right approach is taken.

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Skill-mix change in general practice

It is good to see exploratory research on the introduction of new roles in general practice in Manchester and we agree with the conclusion of Nelson *et al* that introducing new roles to general practice is not a simple process.¹ However, we

disagree with the assertion by the authors that '*Limited evidence suggests PAs may provide safe and effective care that is acceptable to patients but may also generate activity in terms of return and visits, tests, or prescriptions ordered, and referrals.*'

Our comparative observational study of 2086 records of patients presenting at same-day appointments in 12 general practices in England (funded by the National Institute for Health Research) published in this journal² found that there '*... were no significant differences in the rates of re-consultation (rate ratio 1.24, 95% confidence interval [CI] = 0.86 to 1.79, P = 0.25). There were no differences in rates of diagnostic tests ordered (1.08, 95% CI = 0.89 to 1.30, P = 0.44), referrals (0.95, 95% CI = 0.63 to 1.43, P = 0.80), prescriptions issued (1.16, 95% CI = 0.87 to 1.53, P = 0.31), or patient satisfaction (1.00, 95% CI = 0.42 to 2.36, P = 0.99). Records of initial consultations of 79.2% (n = 145) of PAs and 48.3% (n = 99) of GPs were judged appropriate by independent GPs (P < 0.001). The adjusted average PA consultation was 5.8 minutes longer than the GP consultation (95% CI = 2.46 to 7.1; P < 0.001); cost per consultation was GBP £6.22 [US\$10.15] lower (95% CI = -7.61 to -2.46, P < 0.001).*'

We concluded that the processes and outcomes of PA and GP consultations for same-day appointment patients are similar at a lower consultation cost.

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MUS and adverse experiences

Delighted to see the response from Sarah Evans.¹ Adverse childhood experience and relational trauma in particular are now recognised to be potent and widespread causes of MUS. As the effects are registered and maintained sub-cortically, in the limbic brain and in the lower, reptilian, brain, it should be no surprise that CBT is of limited benefit. Neuroscience has met psychotherapy in recent years and trauma-focused therapies such as Somatic Experiencing (Dr Peter Levine, <https://www.seauk.org.uk>, as referenced by Sarah), Sensorimotor Psychotherapy (Dr Pat Ogden, <https://www.sensorimotorpsychotherapy.org>), and Internal Family Systems (IFS, Dr Richard Schwartz, <https://www.internalfamilysystemstraining.co.uk>) are all proving to be much more effective in addressing the somatic expressions of post-psyche trauma and adversity than psychodynamic, CBT, psychoanalysis, or indeed many of the other traditional relational/attachment-oriented therapies. The body is increasingly being recognised as a seat of the unconscious and presentations are as many and varied as the body is complex. Dr Gabor Maté, GP and trauma and addiction specialist, has much useful to say on this also (<https://drgabormate.com>).

NHS provision of trauma assessment and management is patchy but improving. Complex PTSD has only just made it into ICD11 and is undoubtedly at the root of many MUS, but relevant services are some years down the line yet.

I would encourage all GPs to carry out a short trauma assessment interview for all their regular attenders, MUS, and heartsinks. You will be surprised at what is lurking in the past experiences of these patients, and, now that we have effective therapies, equally surprised at how quickly they respond to these new tailored interventions.

To get quickly up to speed with developments in this area I would highly recommend reading *The Body Keeps the Score* by Professor Bessel van der Kolk. (Penguin, 2015, ISBN 978-0141978611).

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Raising the profile of academic general practice to our medical students

Lamb and Alberti¹ highlight the disappointing figure that only 3% of medical students associate general practice with being an intellectually challenging career.² I am a medical student in my penultimate year and am hoping to pursue a career in general practice that I believe will be stimulating, varied, and intellectually challenging.

So how have I come to be a part of this 3%? Well, Lamb and Alberti are right that it is the result of experiencing high-level thinking in general practice. I have done a student-selected component in general practice; an intercalation involving general practice research; and I have attended general practice conferences. Having no preselected specialty when I arrived at medical school, I can truly say that my

perspective is a result of this experience.

However, the suggestion that I can only be intellectually challenged in general practice by pursuing an academic training pathway is simply reinforcing the idea that general practice is not enough.

In 2011, Katerndahl *et al* demonstrated that the complexity of care delivered in the average general practice consultation was greater than the hospital specialties observed.³ The average consultation is built upon a multitude of theoretical principles (for example, continuity of care) that makes each encounter a significant academic challenge.

It is time that medical educators acknowledge the academic rigour of general practice itself and therefore teach, assess, and value the high-level thinking required to be a GP. I hope that all students can be given the opportunity to see general practice from this perspective, by making its principles a standard element of the curriculum rather than an added extra.

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Correction

In Research by Nelson PA *et al*. Skill-mix change in general practice: a qualitative comparison of three 'new' non-medical roles in English primary care. *Br J Gen Pract* 2019; DOI: <https://doi.org/10.3399/bjgp19X704117>, Box 1 had incorrect text in the second column, fifth bullet point. The text should read: 'Limited evidence suggests PAs may provide safe and effective care that is acceptable to patients and that for less medically complex patients, compared to care from a GP, PAs may not increase return visits, tests/prescriptions ordered or referrals made (although total costs of treatment are unknown);⁹'. This has been corrected in the online version.

DOI: <https://doi.org/10.3399/bjgp19X705041>