Letters

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Editor's choice

Consultation length

I have read the flurry of letters concerning consultation length with dismay.[1] The call to move to a 15-minute appointment system seems to be gaining ground without any clear argument other than that it is the 'right thing to do'. May I offer a dissenting voice? The right thing to do is to give people the care they need, and the time needed to provide that care. With effective pre-consultation triage, we can customise our appointment offer to the need. At our surgery, we run 5-minute appointments through the day highly successfully. Patients can also have up to 30 minutes if needed. Having fixed 15-minute appointments is a reflection of a doctor-centred 'we know best' approach. Let's be flexible, and provide what people need, not what we think is best for them.

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Slumber at scale: a digital solution for a tiresome problem

We are grateful to Dr Judith Davidson and her team from Canada for their focus on this highly prevalent condition and for highlighting the effectiveness of cognitive behavioural therapy (CBT) for insomnia within primary care.[1] Indeed, CBT is the treatment of choice according to clinical guidelines. A significant challenge however is how to deliver effective treatment at scale. Certainly within the NHS, where some 12 million prescriptions for sleeping pills are still written annually, it is difficult to imagine there being an adequate supply of clinical psychologists or trained therapists to deliver this CBT. Both logistical and financial barriers suggest that we must look to a more pragmatic and scalable solution.

Digital CBT directly addresses this impasse, offering a demonstrably effective, accessible solution that is also readily scalable and cost-effective. The evidence is strong for equivalence in treatment outcomes between this and more traditional modes of delivery, yet the ability to immediately apply it at population scale is a unique benefit. In addition, the positive outcomes permeate through other health domains with significant improvements shown in mental health and wellbeing.[2,3] Brief clinical tools such as the two-item Sleep Condition Indicator (SCI-02)[4] are also now available to appraise insomnia in general practice. They are well validated and memorable enough to screen for the majority of cases.

GPs have been calling for a solution to the escalating hypnotic prescribing problem and digital CBT can provide it. Sleepio (https://www.sleepio.com/) is one such programme that is referenced as clinically effective in international clinical guidelines, has been subject to NICE MIB briefing, and, through NHS innovation funding, it is being rolled out across London and the Thames Valley. Minimal training is required for this type of automated digital medicine and ways of delivering digital therapies to patients in primary care are being developed. Further work is needed to understand exactly how such solutions can be recommended or prescribed by primary care clinicians; however, the potential for evidence-based digital CBT to satisfy clinical demand for an effective insomnia treatment is compelling. A radical, population-scale approach to this most ubiquitous of problems is long overdue.

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Competing interests

CAE is the co-founder and Chief Medical Officer, DG the UK Clinical Engagement Lead, and IW a Clinical Associate of Big Health (Sleepio). CAE is a shareholder in Big Health, DG is salaried by Big Health, and IW consults for Big Health.

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Commissioning

The editorial on commissioning is very relevant in today's clinical climate,[1] where demands and expectations are soaring and resources are stretched. Involvement of clinicians in decision making is of paramount importance, as spotlighted in this article.

It has been a number of years since CCGs began to involve clinicians. The article perhaps falls short of mentioning the challenges faced by those who took up the task to engage in commissioning and what has been the success. One wonders if any research has been conducted on satisfaction and other outcomes for the clinicians who were involved. One also wonders what are the common barriers that still keep many

GPs rather distant from engagement in commissioning.

Most of us acquire non-clinical skills over time, mostly on an *ad hoc* basis. There needs to be a robust system to hone such skills. Working together in an integrated system of delivery is a wonderful concept in this resource-limited environment, but continuity of care must not be compromised. Continuity of care not only gives the patient a better experience but is also associated with better clinical outcomes. Further discussion is needed on the issues highlighted in this article.

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Maternal depression and primary healthcare use for children

In the article on maternal depression and primary healthcare use for children by Lyngsøe *et al*[1] we suggest that the severity of depression could have been included within the categories measured. The ICD-10 defines depression as mild, moderate, and severe, as within each of these categories there is a drastic variation in the presentation and severity of the symptoms. This could have had an effect on the likelihood and frequency of mothers requiring healthcare services for their child and would allow for a useful comparison between severity of mental state and use of primary healthcare services.

Second, we think that physical comorbidities should have been considered as a covariate. Physical illness could be a confounding factor for two reasons: the mother's physical health could have affected the child's, and also that acutely unwell mothers may have discussed their child's health at their own consultation. These factors would have affected the number of contacts recorded and help to explain the higher rate of positive tests in these children.

Lastly, we feel that it is important to explore whether the findings and trends persist after the first 6 years of life before being able to generalise to all children in Denmark.

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Gatekeeper functions of general practices regarding behavioural addiction

The World Health Organization will classify video game addiction (VGA) as a mental disorder in their 11th revision of ICD, so this new disorder's significance and the great need for prevention by health care must be pointed out.[1] Playing video games can be interpreted as a non-financial version of gambling,[2] so the same dimensions should be considered with both. More and more studies emphasise VGA's spreading tendencies and seriousness in public health. Though only 5–10% of the population reaches the level of diagnosability, this is not a realistic representation of the ones who are at the subclinical level.[3] Because of its economic development, Germany is the most threatened country in Central Europe, with fast and expanded internet access and high-tech digital devices in households.[4] In the US, 99% of 2–17-year-old boys and 94% of girls regularly play video games, and are at high risk of developing addiction.[5] Moreover, the new generation's Maslow pyramid might have changed, as at the bottom of it biological needs have been replaced by non-stop online presence as the most important basic need. A great plan to increase prevention comes from the US too. The legislation called 'SMART Act' (Social Media Addiction Reduction Technology) would force social media companies to take action and try to reduce the risks of internet addiction and psychological exploitation.[6]

It is necessary to use standardised questionnaires to detect all behavioural addiction. GPs can make a lot of difference to help the population maintain their mental health and wellbeing by screening patients to detect symptoms of behavioural addiction.

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