Letters

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Cum Scientia Caritas?

The RCGP's motto *'Cum Scientia Caritas'* can be roughly translated as 'with knowledge, love'. But what should *'caritas'* mean to GPs?

Those who have been to enough weddings may recognise the immortal words of St Paul's letter to the Corinthians in the Bible,[1] *'love is patient, love is kind …'* but we may be surprised to find that it is this word, *caritas*, that St Paul uses to describe love. We may be thinking, *'Beneficence I can do, patience and kindness, yes … but love?'*

In his essay *The Four Loves*,[2] CS Lewis describes the types of love referred to in the Bible, including *'agape'*, the highest form of love: the divine, unconditional, self-giving love, most perfectly exhibited in the way that Jesus sacrificed himself on the cross for others. It is this word, *'agape'*, that, when translated from the original Greek, was rendered *caritas* in the Latin version of St Paul's letter.

Thus, our motto calls us to love our patients unconditionally and selflessly! Surely, even the most progressive advocates of patient-centred care wouldn't go this far? At this point, we must either accept that *'Cum Scientia Caritas'* is just a nice sounding but ultimately meaningless phrase, or, boldly, we begin to bring *caritas* to work.

Compassion, a more familiar word, captures the essence of *caritas*. It derives from the Latin *'cum'* and *'passus'* meaning 'to suffer with'. Compassion is more than a felt reaction to suffering: instead, it is a sense of truly being together. It is at the very heart of being human: noticing, interpreting, and taking action to alleviate suffering by being fully present.

So, honouring our motto, how should we best serve our patients with *caritas* as well as knowledge? How can we be selfless, unconditionally loving, and compassionate? We can start by selflessly giving the fullness of our attention to each patient. We can treat every patient with unconditional kindness, regardless of their background or situation. When all else fails, sometimes the best we can do is simply be with our patients in the midst of their pain, and, in a sense, suffer with them.

Fraser Barratt
GP Trainee, Edinburgh.

Email: **fraser.barratt@nhs.scot**
@FSBarratt

Liz Grant
Professor of Global Health and Development, Director Global Health Academy, Assistant Principal Global Health, Programme Co-Director (MSc Planetary Health, Global Health Challenges, Master of Family Medicine), Usher Institute and Edinburgh Futures Institute, University of Edinburgh, Edinburgh.

Scott A Murray MBE
Emeritus Professor of Primary Palliative Care, Usher Institute, University of Edinburgh, Edinburgh.

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'Is there a doctor on board?' The development of a bespoke 'Good Samaritan' course for GP trainees

'Is there a doctor on board?'

A sentence that puts trepidation in the hearts of many doctors, yet most of us would step up to help in a medical emergency. But should we? Must we? Do we have the skills? Would our medical insurance cover us? These are some of the questions Good Samaritan situations pose.

To explore this further, an online questionnaire was sent to all GP trainees on the Dorset Vocational Training Scheme. We found that 70% had responded as a Good Samaritan, 42% once or twice, and several >10 times. These incidents typically occurred on a plane, footpath, at a road traffic accident, or in a family home. We also found that 51% reported no previous training in Good Samaritan acts and 70% wanted more training in all aspects of the clinical and professional requirements, as well as in medico-legal implications.

In response, a 1-day course was delivered to 45 final-year GP trainees, using simulation-based workshops in an outdoor beach setting. Workshops included falls from a bridge; cervical spine assessment; hypo and hyperthermia on the beach; assessing a casualty with painful leg at a simulated road traffic accident. The course also provided ethical and legal considerations of the Good Samaritan role, and a focus on leadership, team working, handover, and effective communication.

Feedback was overwhelmingly positive, with all responders stating they would recommend this course to a colleague; all felt more confident in attending a clinical situation as a Good Samaritan; and all felt more confident in the legal and ethical obligations of a doctor. Participants felt 'empowered' and found the course 'excellent', 'engaging', and 'inspiring'.

As health professionals we may be called upon to help with a medical incident when we are off duty. All eyes are upon us as doctors with an expectation that we will know what to do. When coming across an emergency we need confidence in our clinical ability, non-technical skills, and our legal and ethical boundaries. Simulation-based training in real-life environments is the best way of upskilling doctors to feel confident, and be competent, to offer their clinical skills in unfamiliar environments.

Emer Forde
GP Programme Director, Thames Valley and Wessex Primary Care School, NHS England South East.

Email: emer.forde4@nhs.net

Lucy Obolensky
Associate Professor of Global Health & Remote Medicine, University of Plymouth, Plymouth.

Alex Cross
Consultant Emergency and Prehospital Emergency Medicine, Royal Devon University Hospitals, Exeter.

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'Sludge audits' are needed to reduce barriers to care

Hodson *et al*'s piece[1] in the April edition of your esteemed journal brought back vivid memories of being packed off to Torquay, at significant NHS expense, to be told in an enormous conference hall of the merits of Advanced Access in general practice. This bright idea, seeing 'today's patients today', was basically an exquisite way of stressing GPs.[2] It made no difference to patient care,[3] but that did not stop it being translated into patient access targets.

All healthcare delivery involves delays. Notwithstanding any 'sludge' issues, there is always the 'twinge to treatment' gap: the time from first symptoms, to decision to consult, to actually consulting. Since they have always been with us, the evidence and the textbooks have all been compiled in the context of these delays: it is not possible to gather data about a situation that has never existed. The presence of delays predicates all that we know about clinical practice, and clinical decision making.

If this alters, and patients are seen more quickly, would GP decision making still work? Would a new literature be required? Would there need to be parallel sets of evidence to accommodate patients who chose to wait for their favoured GP?[2] What is the optimum twinge to treatment gap?

By all means we should listen to our patients and get rid of unnecessary delays to care; apart from anything else, inefficient systems are no good for the NHS either. And our patients may feel there is more sludge than is the reality. But a bit of sludge should be celebrated, to pause and reflect, lest the baby be thrown out with the bathwater.

Ed Warren
Retired GP, NHS GP (emeritus), Cumberworth.

Email: **ed.warren@hotmail.co.uk**

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The 'burden' of eye conditions

One of the benefits of being a GP is the variety, so in my view eye conditions are not a burden, but a diversion as they usually present as a single problem consultation. Keeping up to date with the evidence and clinical skills would be lost if these patients were diverted at triage stage (as it has in maternity care and much neurology, heart failure, etc.) to the detriment of job satisfaction and frustration for patients. Having easy-to-find and speedy access for the minority of people needing more skills and equipment is a prerequisite though.

John Sharvill
GP, NHS and voluntary sector.

Email: john.sharvill@gmail.com

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Assessment and treatment of reflux-like symptoms in the community

Many thanks for this article, which brings the importance of lifestyle medicine into focus.[1] This is such an important topic for primary care given that GPs see high numbers of patients with reflux symptoms. It is amazing to read that lifestyle changes are at the forefront of management. With the rising concerns about side effects with proton pump inhibitors (PPIs), not forgetting the increasing prevalence of reflux symptoms among both the ageing population and children, it could not be a more apt time to focus on this issue holistically.[2]

Patient education remains at the forefront of this and the idea of involving pharmacists seems vital. Pharmacists can educate the patient not just on relevant lifestyle changes but also to pick up on repeat prescriptions of PPIs. Despite time constraints, GPs still play a pivotal role in highlighting the impact of lifestyle changes for reflux symptoms as well as side effects of PPIs. The evidence that the doctor–patient relationship has an impact on prescribing is not new.[3] With a multidisciplinary perspective, involving healthcare assistants, physician associates, and nurses in primary care to share the importance of lifestyle changes is a much needed tool when managing reflux symptoms.

With the increasing success of group consultations in primary care, this could be a topic that could be discussed with a focus on lifestyle changes. While we do not want to create negativity towards medication, educating patients on the side effects of PPIs can improve shared and informed decision making.

It would also be something that the National Institute for Health and Care Excellence could take into consideration when reviewing the current management guidelines of gastro-oesophageal reflux disease.[4] Lifestyle management could be the first vital step for management of the condition rather than an element of care.

I include the factsheet that I share with my patients, which has evidence-based lifestyle and dietary changes for acid reflux: https://plantbasedhealthprofessionals.com/wp-content/uploads/2024/01/GORD-factsheet15.01.24.pdf.

Anni Tripathi,
GP, Jersey Practice, Heston.

Email: anni.tripathi@nhs.net

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