2007

Discussion Forum

Postings to the BJGP’s Discussion Forum include responses to articles in the journal or any other issues of relevance to primary care. This document contains previous comments posted on the forum.

http://www.rcgp.org.uk/bjgp-discuss
What you said in 2007

Date: 24 Dec 2007  
Topic: Denial of primary care to vulnerable migrants  
Comments by: Tom Yates, 5th year Medical Student, Cambridge; Virginia Leggatt, Physician, Medical Foundation for the Care of Victims of Torture, London

The Department of Health and Home Office are reviewing access to NHS services for foreign nationals and are due to report shortly. If, as expected,\(^1,2\) rules governing access to primary care are aligned with those governing hospital care, victims of trafficking, undocumented migrants, and refused asylum seekers will lose the right to access freely many NHS primary care services. This group includes those unable to return to their country of origin because this is deemed unsafe, either on medical grounds or for reasons of security. As these individuals are entitled to claim National Asylum Support Service assistance, it seems inconsistent to deny them access to primary care.

Clearly, the majority of this group are unable to pay private healthcare costs\(^3\) so if these proposals are implemented, they will be denied access to almost all health care. Evidence is growing\(^4\) that the 2004 hospital charging regulations have led to care being denied not only to refused asylum seekers, but also to other vulnerable individuals with every right to free NHS care. It seems likely that, if the rules governing access to primary care are changed, similar errors will occur.

Migrant children denied primary care would be unlikely to receive childhood vaccinations, reducing herd immunity and endangering their peers. In addition, many migrants with worrying symptoms who are denied investigation in primary care will appear in accident and emergency departments, where care is significantly more expensive. Delayed diagnosis of communicable diseases could have implications not only for the individuals concerned but also for the whole community. Managing advanced illness once treatment has been deemed ‘immediate and necessary’ will be much more costly.

Without increased funding for administration, charging in primary care is unlikely to be workable.\(^5\) The only health impact assessment of such charging suggested that, even in areas accepting large numbers of migrants, foreign nationals are unlikely to place significant burdens upon primary care services and that the costs of administering any charging regime are unlikely to be recouped.\(^5\) There are other practical considerations, including liability when harm accrues to patients.

We consider it unethical to use the deliberate denial of health care to enforce immigration policy. We do not believe that it is the role of GPs to police such policies and urge those who agree to make submissions to the Department of Health consultation that will follow the publication of the review.

Reference
In the September issue of this journal, White et al.\(^1\) reported on the feasibility and usefulness of remote electronic reporting (by e-mail) of primary care based spirometry. They conclude that the quality of spirometry tests was low and the agreement between specialists and GPs on acceptability was slight, and on diagnosis was fair. The authors’ advice to investigate next if quality of spirometry testing and interpretation in primary care can be improved by remote electronic reporting.

Although the paper provides some interesting new information, there is also much that the authors do not report. For instance, the paper only reports on the acceptability of spirometry tests in terms of agreement between the GP and the respiratory specialist. More details about the actual quality of the submitted spirometry tests would be required to be able to verify the authors’ conclusion that the ‘quality of the spirometry done in primary care was unsatisfactory’

Despite these shortcomings in the study methods used, we agree with the authors that some kind of continuous support for GPs is necessary to improve test quality as well as interpretation of the test results.\(^2\) We recently reported that the use of a computerized expert system for the interpretation of the spirometry test results had no benefit for the acuity of GPs’ diagnosis and subsequent management changes.\(^3\) From another study we know that chest physicians can give valid interpretations of lung function when they just receive written information without actually seeing the patient.\(^4\)

So what need to happen next? There is an increased awareness by government authorities, insurance companies, and healthcare professionals that primary care spirometry testing needs to be accredited in some way.\(^5\) Therefore, in the Netherlands the COPD and asthma general practice advisory group (http://www.cahag.nl/) and all other disciplines involved in primary care spirometry (i.e. lung function technicians, chest physicians, GPs, practice nurses) will soon start unfolding a nationwide programme to enhance the quality of primary care spirometry.

This programme consist of three elements: (1) improving training (e.g. clarifying the minimum requirements of a spirometry training like has previously been done in New Zealand,\(^6\) use of standardised educational materials like CD-ROM Spirometry Fundamentals\(^7\)); (2) improving organisation (e.g. describing standards for minimum practice organisation and protocols for cooperation with secondary care); and (3) improving quality assurance (e.g. periodic outreach visit by lung function technicians,\(^8\) incorporation of spirometry quality indicators in practice accreditation, and a system of registration of the spirometry driver license).

We believe that only with such coordinated efforts spirometry performance and interpretation in primary care can be enhanced structurally.

**References**


Date: 19 Nov 2007
Topic: Personal and public health care
Comments by: David Church, GP, Machynlleth, Powys
I would tend to disagree with Prof. Abholz’s view that it is only within the last few years that GPs have seen a shift from personal to public health roles. And as a result or implemented by QOF or EBM.

It may be true of GPs in other countries, but British GPs have had a strong duty and role in public health as well as personal care for centuries, possibly longer, depending on one's view of the origin date of general practice.

At medical schools in the 1980s there was good grounding in public health for all of us, not just GPs, from departments as diverse as ‘Man in Society’, ‘Infection Control’, and Microbiology, for a start. Indeed, the Leeds School (and no doubt others) was set up partly around and involving the staff of the Public Dispensary. However, going back further, there were huge contributions to social medicine by local authorities under the Poor Laws (when properly discharged), and their predecessors, the Parish Wardens, using general medical manpower when needed.

Certain instances of historical public medicine are rightly famous in Britain – the Broad Street Pump, for example, and William Pickles. Going back even further, there is evidence that roman military forces in Britain were served by attached medical staff who, being part of the military establishment would have had loyalties to the Legion as well as the individual, and so were taking public health into consideration.

I think it is an integral part of medical tradition in Britain to be aware of the public health effects of individual illness and treatment, and one of which we can and should be proud.

Reference
Date: 19 Nov 2007  
Topic: Death certification  
Comments by: Dr M G Bamber and Dr A McKechnie, The Surgery, Back Lane, Colsterworth, Grantham, Lincs

I read your paper in the Back Pages of the *BJGP*¹ with increasing sadness. The purpose of a death certificate is primarily to state the cause of death, while the other two functions you cite are soft accompaniments.

Your example where you state that there was ‘… no doubt at all that death was from natural causes’ depressed me in a journal designed to educate its readers. My increasingly unfashionable view is that the doctor should try to find the cause of every death. How can you expect the state of the nation’s health to be assessed from guesses and kind words on death certificates designed to be ‘acceptable to both the registrar and the family’?

The reluctance to both variously request and finance autopsies has now produced the situation that a doctor can train as a histopathologist in the UK without ever having done an autopsy. Many young doctors have not seen, let alone performed, an autopsy. Some conditions identified after death may have real relevance to surviving relatives and medical and nursing attendants. My anecdotal favourites in my career to date have been aortic aneurysms and tuberculosis.

Peter Davies elsewhere in the same edition of the Journal² quotes Raymond Tallis referring to ‘sessional functionaries robotically following guidelines’.

Please be more inspiring and reactionary, if only for the sake of younger colleagues alone, so that Tallis’ observation can be reversed.

References

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Date: 4 Oct 2007  
Topic: Primary care spirometry  
Comments by: Paul J Nicholson OBE FRCP FFOM MRCGP, London

Guidelines for the care of patients with chronic obstructive pulmonary disease (COPD)¹ and those for asthma² encourage the objective assessment of lung function at all levels of health care. However, limited data are available on the quality of spirometry performed in primary care. Since spirometry is incentivised by the Quality Outcomes Framework, the study by White et al³ in this journal (Sept 07 issue) is important, as is a coincidental study in the US that shows that of 368 tests completed in primary care over 6 months, 71% were technically adequate for interpretation and that family physician and pulmonary expert interpretations were concordant in 76% of tests.⁴

White et al challenge an ‘unstated assumption’ that the professionalism of primary care clinicians will ensure that spirometry is performed to an acceptable standard.³ Wherever this assumption might exist, it must be purged actively. Spirometry is among the most useful and accurate measures of respiratory health, however, when not performed correctly, it can lead to misdiagnosis and mismanagement. Like many health measurements, spirometry is subject to measurement error. Measurements of the same quantity can vary in the same individual, from one day to another, in different hands, with different equipment, at different centres. Error may arise in the subject, the observer and/or the measurement process. In spirometry, the most common cause of erroneous results is sub-optimal patient coaching.³ Thus
spirometry requires specific training over and above basic professional training. NICE guidelines emphasise the need for appropriate training and for competence in the interpretation of spirometry results.1

White et al state that there is currently no standard for the training and conduct of primary care spirometry. As an occupational physician responsible for spirometry programmes in a non-hospital setting, I argue that the competence of clinicians performing spirometry and interpreting results are identical, irrespective of the clinical setting. Of note, the Association for Respiratory Technology and Physiology (ARTP) with the British Thoracic Society (BTS) provide a competence qualification in spirometry. The certificate in spirometry incorporates competence assessment via a training course run at over 20 centres nationwide, a written assignment, a portfolio of examples and a short practical exam and viva. The certificate is noted to be useful for nurses in both primary and secondary care.6

The authors methodology required practices to perform spirometry according to the 1994 update of the American Thoracic Society (ATS) guidelines.7 However, these were superseded in 2005 by joint ATS and European Respiratory Society (ERS) guidelines that are available for free online.8

The authors point out that the quality of spirometry is likely to be determined by several factors including the quality and length of spirometry training, the aptitude of the spirometry technician, supervision after completion of training, and the quality of test interpretation. The ATS and ERS also published guidelines on interpretative strategies for lung function tests in 2005.9 These too are available for free online.

Eaton et al’s study of spirometry in primary care practice demonstrated that non-acceptability of results was largely ascribable to failure to satisfy end-of-test criteria.10 Failure to use appropriately calibrated/prepared equipment is another concern.11 These issues emphasise the importance not only of effective training but also of effective quality assurance programmes. The ARTP, BTS, and British Lung Foundation want the mandatory implementation of quality assurance measures for all NHS personnel performing spirometry within by 2010.10 Given that standards do exist, spirometry in primary care is instantly amenable to clinical audit, peer review and therefore quality improvement. Specialist reporting of spirometry conducted in primary care, as studied by White et al, could prove to be a useful quality improvement tool, but adequate training of those performing spirometry must to be the primary corrective measure to correct this quality non-conformance.

References
4. Yawn BP, Enright PL, Lemanske RF, et al. Spirometry can be done in family physicians' offices and alters clinical decisions in management of asthma and COPD. Chest, 2007 Jun 5 [Epub ahead of print].
5. Enright PL. How to make sure your spirometry tests are of good quality. Respir Care, 2003;48:773-776.
Is it difficult to get a fast, convenient or personalized appointment with a GP?

Chris Salisbury et al's two papers in the August BJGP investigated the effects of the introduction of the 'Advance Access' scheme. The scheme was meant to fix the perceived problem that patients couldn't get to consult a GP quickly. The studies showed that in reality Advance Access was not needed, fixed nothing, and produced only marginal changes. The Department of Health's national access survey investigated but did not confirm the perception that getting an appointment with a GP was difficult. In some areas there may be problems. In my own practice the survey reported that 18% of patients felt they couldn't get an appointment within 48 hours, but we think we have plenty of unbooked appointments at the start of each day and if there is no additional unbooked appointment available we will always see patients the same day if they want. These gaps between perception and reality need acknowledging and addressing.

Primary health care services are being compared with services like supermarkets that seem to be open to sell all things, to all people, all of the time, almost everywhere. GPs feel under pressure to copy the supermarket example but if GPs do provide enough appointment then the problem might be the public's perception of what's on offer.

Patients want a choice of appointments that includes a fast service (that is, same day), a convenient service (at a day and time of the patient's choice), and a personalized service (with a doctor of their choice within a few working days). GPs can never guarantee that an appointment is fast, convenient, and personalized but they can make the choice between these services (and their consequences) clearer for patients. If GPs do under provide, poorly describe, or badly explain their services, it's like supermarkets failing to stock their shelves with plainly labeled products and with no instructions on how to use the products.

The stock of appointments needs to be relabeled in terms that the patients understand like fast, convenient or personalized appointments. Clear instructions on how to use the fast 'same day', convenient appointment with any GP and the personalized appointment with a named GP can help patients choose what they want, and know what they can expect in that appointment.

Unlike supermarkets, primary health care in the UK really is accessible for all people, all of the time, almost everywhere. Patients will soon enjoy even more choice about who, when, where, and how they access and use primary health care as the patient's NHS summary care record becomes widely available.

If it is easy to get a fast, convenient or personalized appointment with a GP then the gap between perception and reality is a marketing failure that the NHS needs to fix with better advertising of its GP services.
References

Date: 4 Oct 2007
Topic: 'Connected care in a fragmented world'
Comments by: Dr Jane Wilcock, GP, The Lowry Medical Practice, Pendlebury Health Centre, Swinton, Manchester

I would like to hug Jane Farmer for a wonderful clear, bold article stating the real values of general practice both to patients and GPs!

After years of feeling that I am out of date and old fashioned in my GP values and unfashionably remaining in the same practice for 20 years I have read a supportive article. The political society we read about subscribes to portfolio careers and valuing fame, choice and change but here’s to all those GPs who are quietly going about their careers trying to offer consistency and high quality health care across the UK.

Reference

Date: 16 Aug 2007
Topic: NICE fever advice
Comments by: Wouter Havinga

The NICE guidelines for ‘Feverish illness in young children’ is a document that contains useful practical advice on fever care. It illustrates that when dealing with a child with fever, the issue is to exclude an underlying dangerous infection rather than treating the fever with antipyretic interventions. This gives the opportunity for every clinician to give the same confidence-building message to the public.

- Antipyretic agents (paracetamol and ibuprofen) should not be used routinely with the sole aim of reducing body temperature in children with fever who are otherwise well.
- Antipyretic agents do not prevent febrile convulsions and should not be used specifically for this purpose.
- Paracetamol and ibuprofen should not routinely be given alternately to children with fever.
- Tepid sponging is not recommended for the treatment of fever.
- Children with fever should not be under dressed or over wrapped.
- The use of antipyretic agents should be considered in children with fever who appear distressed or unwell. Either paracetamol or ibuprofen can be used to reduce
temperature in children with fever. Paracetamol and ibuprofen should not be administered at the same time to children with fever.¹

To build confidence in parents who are caring for feverish children, it is essential that health professionals stop maintaining two medical myths, the first that fevers can get too high and death ensues; and second, that febrile convulsions happen when the temperature gets too high. These two myths are the cause for the widespread anxiety about fever. Furthermore, doctors believe that reducing the temperature makes the child feel more comfortable. The result of the advice ‘to manage the fever’ gives parents the impression that the temperature should be reduced and is often advised as such by clinicians. However, the above bullet points illustrate otherwise. This is important because every practicing doctor in the out-of-hours service is aware of phone calls from parents who ring in a panic because they realise that they ‘cannot control the temperature’.

This iatrogenic fever phobia is a frequent cause for distress in parents, which has its effects on the child, and the health professionals who deal with the caller. Due to the frequency of these type of calls, it puts pressure on the out-of-hours service. The outdated advice ‘to manage the fever’ or ‘to control the fever’ is potentially resulting in a second call during the same shift when the temperature is not responding, and this again is the cause for attendances to the primary care centres and subsequent contacts with the paediatric departments and admissions.

Rather than advising to fear and fight a fever, doctors can give advice that supports the fever process and, as such, build confidence in parents caring for their feverish child. Implementing this NICE advice and organising a public awareness campaign to support the fever process has the potential to create health gains for all involved and financial gains for the PCTs due to less pressure on the services.

Reference


Date: 16 Aug 2007
Topic: Defined daily dose for topical NSAID use – clinical update
Comments by: D Carnes, PL Cross, and M Underwood

For the purposes of a randomised controlled trial (RCT) comparing the effectiveness of topical versus oral ibuprofen for chronic knee pain in primary care, we needed a defined daily dose of topical ibuprofen required to treat one knee (TOIB study ISRCTN 7935305).

With the exception of diclofenac in dimethyl sulfoxide cutaneous solution, the dosage regimens for topical non-steroidal anti-inflammatory drugs (NSAIDs) given in the BNF and patient information sheets are vague. A maximum daily amount of 15g is suggested for ketoprofen gel, and 25g for one preparation of felbinac gel, but these are total daily doses, not per joint. No specific amount is given for ibuprofen gel. Nor were the manufacturers able to give advice on a normal dose for one knee.

Some ex vivo studies of the penetration of ibuprofen into the knee joint and peri-articular structures have specified a daily dose of topical ibuprofen. However, the amount used in these studies was substantially larger than the dose one might expect to use in routine practice: 7.5g of 5% ibuprofen gel three times daily, which provides 1125 mg of ibuprofen per day from 22.5g of gel. This dosage regimen would mean that a 100g tube of gel would last just 4.4 days, which would be unrealistic for routine use. To establish a realistic defined daily dose for topical NSAID use for knee pain we used two approaches:
1. A typical loading dose for topical preparations is 2mg vehicle/cm² of skin (personal communication Marie Miller, Dermal Laboratories.) We were unable to identify any previous estimates for the surface area of the skin over the knee or those parts of the knee to which patients typically apply topical preparations. Therefore we estimated the knee surface by considering the knee as a cylinder. One of our research team (DC) measured the knees of 15 members of the public, all over 35 years of age. Measurements were taken of the circumference of the extended knee at three levels: the superior aspect of the lateral and medial condyles of the femur, the joint line, and the tibial tuberosity. The mean of these values was taken to be the circumference.

We also measured the vertical height of the extended knee from the superior border of the patella to the insertion of the patella tendon at the tibial tuberosity. Mean circumference was 39.4cm and height 13.9cm giving a surface area of 548cm². We then halved this figure because in our clinical experience topical NSAIDs are generally applied to the anterior aspect of the knee only, giving an area of 274 cm², which was multiplied by 2mg to provide an estimate of a single application (0.55g). Although the surface area of the knees measured may not be completely representative of the population with chronic knee pain, and the surface area of the knee varies slightly according to the degree of flexion; these results are likely to be sufficiently accurate for our purpose.

2. The fingertip unit of creams and ointments was developed as a guide for the use of topical steroid preparations for dermatological practice. It is used to help patients assess how much topical steroid to use. The unit equates to approximately 2.5 cm of cream or ointment, the length of the distal phalanx of the index finger; it weighs approximately 0.5g and covers approximately 312cm², an area similar to that of the anterior aspect of the knee. This approach suggests that a single application of ointment is 0.5 gram.

Both approaches came up with a similar value. We therefore defined a single application as 0.5g. Manufacturers typically recommend topical ibuprofen application three or four times per day. We standardised a three times daily regimen for all preparations. This made a defined daily application of a topical NSAID cream, gel, or ointment for one knee 1.5 g, which for ibuprofen 5% equates to 75mg ibuprofen per day (a 10% preparation concentration would equate to 150mg).

These doses of ibuprofen are substantially less than the 1125mg/day used in ex vivo penetration studies: 7% of that used by Dominkus. Few prescriptions for oral NSAIDs are for more than 200g; and, according to the pharmaceutical company estimate of 2mg/cm², to rub in the 7.5g of vehicle used for one dose by Dominkus a skin area of 3750cm² would be required. We recognise that the amount of active ingredient absorbed will vary, depending on the concentration of the preparation. However, the actual amount of vehicle applied is likely to be unaffected by the concentration of any active ingredients. We feel confident that 1.5g is a realistic defined daily dose of topical NSAID for one knee.

This calculation will serve to inform clinicians and researchers on the appropriate dosage for topical NSAIDs.

References
We read the article recently published by Holm et al\(^1\) on the aetiology of lower respiratory tract infections with interest. In this article, the authors only reported 16.8% of bacterial aetiology among the patients with non-pneumonic infections of the lower respiratory tract. In this study Streptococcus pneumoniae was the most frequent among the bacterial agents observed, being isolated in one third of the bacterial infections followed by Haemophilus influenzae in 21.7% of the total number of bacterial infections.

The authors comment that expectoration was more frequent among the patients without pneumonia than among those with radiologically confirmed pneumonia. Among the 316 patients with non-pneumonic infections, many were probably exacerbations of chronic bronchitis or even with spirometric diagnosis of COPD. It would therefore be interesting to know the aetiology of these patients since hospital series indicate H. influenzae as the most frequent aetiologic agent.

However, in a study carried out by our group in primary care patients (n = 1947) with exacerbations of chronic bronchitis, the most frequently isolated agent was pneumococcus with almost 35% of all the bacterial causes.\(^2\) On the other hand, in this study H. influenzae, was only responsible for 12.6% of all the exacerbations, being third by order of frequency. If the results obtained by Holm et al were similar in patients with chronic bronchitis, this would further support the different aetiology of the patients within the community setting compared with that of the hospital, which would be explained by the lesser severity of the patients attending our consultation offices.

Since a microbiologic study was performed, it would also be interesting to know, if possible, what diagnoses the respiratory infections by H. influenzae corresponded to and whether there was a correlation between the different aetiologic agents and the concentrations of C-reactive protein and procalcitonin, taking into account that in other studies the highest values of these inflammatory markers seemed to be more associated with pneumococcal infection.\(^3\)

**References**

It was interesting to read the systematic review on prognostic factors for musculoskeletal pain in primary care by Mallen et al and the editorial by Carnes and Underwood (BJGP August 2007).

It is very clear that we need more research on chronic musculoskeletal pain before we could come to any definite conclusion. Cervicogenic headache is a highly controversial issue and had been through much debate. Research has shown that interleukin beta (IL-β) and Tumour Necrosis Factor alpha (TNF-α) have a role in cervicogenic headache. It is possible that a similar mechanism may exist in low back pain and in other musculoskeletal pains. Until we find the biomolecular markers of this condition, it will be misunderstood and treatment will continue to be contaminated by non-scientific practice.

Reference

Date: 9 Aug 2007 21:36
Topic : 10 Downing Street Petition Against 0844 NEG Surgery Line Doctors Numbers
Comments by: a concerned patient

As many GPs will be aware, as the results of the activities of a company called Network Europe Group (NEG) and their activities in marketing a telephone switchboard service solution for doctors’ practices (Surgery Line), many GPs have ditched their conventional local priced 01/02 numbers in favour of 0844 numbers provided by NEG along with the so called ‘free’ new switchboard and call queuing equipment. However, there is a growing movement against the use of these numbers by patients who are wholly opposed to their adoption by their local doctors’ surgeries. Some of these discontented patients have now started a petition against the use of the 0844 NEG numbers by doctors surgeries on the 10 Downing Street petitions website at: http://petitions.pm.gov.uk/NGN-use-by-GPs/

Many patients oppose the use of these 0844 NEG Surgery Line numbers for the following reasons:

1. They are excluded from flat-rate landline calling plans like BT Option 3 where customers pay a fixed price such as £7.99 per month for unlimited 01/02 calls. Instead, 0844 numbers are charged at £3 per hour and are not even the same price as a local rate call (£1.80 per hour) for callers who do not subscribe to a fixed price calling plan.
2. They are excluded from bundled minutes on practically all mobile phone contract bundled minutes plans and also cost extra on pay as you go phones too. Some mobile phone providers charge up to 40p per minute to call an 0844 NEG number. Some mobile phone providers charge up to 40p per minute to call an 0844 NEG number.
3. The 0844 numbers are charged at 13p per minute from BT Payphones compared to 1p per minute for 01/02 numbers from the same BT Payphone.
4. Calls to 0844 numbers from overseas are usually barred as are calls to the 0870 number which is the only one NEG allows doctors using their service to quote as a replacement number. Where the numbers can be called from overseas the cost is often 10 times higher, or more, than calling a UK 01/02 number.
5. The overall view of patients is that, by getting these numbers doctors are putting their own commercial interests first in cutting the budget their practice has to spend on advanced telephone equipment by getting it subsidised through the calls, whereas patients believe doctors should pay for the equipment out of their own budgets and continue to charge their patients for normal priced 01/02 calls.
I would be interested to hear the views of GPs on this matter.

Date: 2 Aug 2007 15:17
Topic: Interpersonal continuity article
Comments by: Kerr L. White M.D.

The BJGP is the best GP/FP by all measures! The piece in the RJGP (July 2007) by Barbara Starfield (the first colleague I appointed when I started the new Department of Health Care Organization at Johns Hopkins in 1965) and John Horder (a long-time friend who I first met in 1959) is a classic! They have boiled down in two-and a half pages the essential contribution of primary care to compassionate and scientifically-informed medical responses to the population's diverse health problems, but also its fundamental role in underpinning any balanced, safe, and cost-effective health care 'system'. The list of references is superb. It is a true classic and copies should be sent to all U.K. MPs and all U.S. Congress Members.

Reference