

and ideas on many health matters. I guarantee that some of them will be outrageous.

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DOI: 10.3399/bjgp12X656720

## 21st century health services challenges for an ageing population

Advance care planning should be added to Oliver's 10 challenges for general practice for an ageing population.<sup>1</sup> Many of the scenarios he describes, such as, multiple conditions, dementia, and repeated hospitalisation, are in fact prognostic markers for end-of-life care. Prognostic indicator guidance is available to assist doctors to identify patients approaching the end of life.<sup>2</sup>

We know that patients at the end of life with non-cancer diagnoses are less likely to be included in practice registers. Timely identification allows for more systematic care based on patient preferences.

The General Medical Council<sup>3</sup> also emphasises a broad non-disease based definition of end of life. Systematic identification of people who are approaching the end of life and advance care planning<sup>4</sup> can be the 'game changer' that is being looked for.

The issues that Oliver has identified are a massive challenge to general practice. At present, it is difficult to see where the solutions are going to come from, with current approaches best characterised as 'fire fighting'. But a way forward must be found with better models of care. The advent of clinical commissioning groups affords the best opportunity for a strategic approach to systematically improve care. Key to this will be how geriatricians and GPs work together, and how general practice capacity and capability increases.<sup>5</sup>

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DOI: 10.3399/bjgp12X656739

## Pharmacovigilance on the turn? Adverse reactions methods in 2012

I was interested to read in the August edition of *BJGP* that there are proposals to involve patients in reporting drug side effects.<sup>1</sup> It is now 30 years since I suggested that patients should be allowed to report suspected side effects of medication to the Committee on Safety of Medicines (CSM). In my proposals any patient prescribed a drug within 1 year of that drug being granted a licence should receive a pre-paid postcard advising them of the novel status of that drug, and advising that they should notify the CSM of any untoward incident or occurrence within a specified period after taking that product. This would extend to reporting any concerns about a child born subsequently, should the patient have been pregnant when taking the drug. In tandem with this, any doctor prescribing a drug within 1 year of licensing should be obliged to report all medical events experienced by the patient during the following 12 months.

Undoubtedly such an arrangement would generate a great deal of spurious

information. However, with the use of computer analysis, common patterns would be easily identifiable. One of the problems with reporting suspected drug side effects is the natural preference of reporting effects that are already known to be associated with a drug. The aim of pharmacovigilance should be to identify quickly unsuspected adverse effects, for example, dry eyes that occurred with beta blockers. During research and development of new drugs there is a tendency for negative attributes of a product to be suppressed, or if developmental trials are abandoned then this is never published. Even in phase 3 trials the follow-up surveillance is often limited in scope and may not identify atypical reactions.

The more general collection of data, as I propose, would include the known reactions, which may be easily filtered out, as well as events that may or may not be of significance. Patterns of recurring similar events could flag up the possible need for more careful scrutiny. The added responsibility on the prescribing doctor may also encourage reflection before using a me-too product introduced at the expiry of a drug patent with little or no advantage over the established and less expensive product.

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DOI: 10.3399/bjgp12X656748

## Looks vestibular: irrational prescribing of antivertiginous drugs for older dizzy patients in general practice

Although there is little evidence for the effectiveness of antivertiginous drugs (AVDs) for dizziness of vestibular origin and no evidence for the effectiveness of AVDs for non-vestibular dizziness,<sup>1</sup> prescribing drugs for dizzy patients in general practice is still common practice. Recent publication of the updated Beers Criteria for potentially inappropriate medication use<sup>2</sup> stimulated

**Table 1. Determinants of prescribing antivertiginous drugs by GPs for older patients with a new episode of non-vestibular dizziness**

Variable	N (%)		Univariate P-value	Multilevel analysis OR (95% CI)
	Prescription of AVD: yes (n = 151)	Prescription of AVD: no (n = 1489)		
<b>Age, years</b>				
65–74	82 (54.3)	710 (47.7)	0.121	
75–84	56 (37.1)	593 (39.8)	0.512	
≥85	13 (8.6)	186 (12.5)	0.164	
Female	110 (72.8)	945 (63.5)	0.022	
<b>Presented dizziness symptom</b>				
Dizziness	95 (62.9)	968 (65.0)	0.607	
Spinning sensation	52 (34.4)	178 (12.0)	<0.001	3.6 (2.4 to 5.4)
Near faint	2 (1.3)	183 (12.3)	<0.001	0.1 (0.04 to 0.5)
Feeling unwell	3 (2.0)	115 (7.7)	0.009	
Lightheadedness	3 (2.0)	75 (5.0)	0.093	
Loss of equilibrium	10 (6.6)	35 (2.4)	0.002	3.7 (1.7 to 8.0)
Unsteadiness	5 (3.3)	39 (2.6)	0.616	
Tendency to fall	4 (2.6)	37 (2.5)	0.902	
Instability	1 (0.7)	32 (2.1)	0.215	
Giddy	0 (0.0)	32 (2.1)	0.069	
Everything turning black	0 (0.0)	30 (2.0)	0.078	

AVD = antivertiginous drug. OR = odds ratio.

us to investigate the prescription of AVDs by GPs in older patients with non-vestibular dizziness and to analyse the relationship between prescribing AVDs and patient's age, sex, and presented dizziness symptom(s).

The data used in this study are derived from the Second Dutch National Survey of General Practice [DNSGP-2].<sup>3,4</sup> For this survey, 195 GPs in 104 practices recorded data about all patient contacts for 12 consecutive months. We extracted patient characteristics, consultation characteristics (symptom[s] presented/new or existing episode), and prescribed drugs. For the identification of our target population (patients aged ≥65 years who visited their GP because of dizziness) we developed an extensive search strategy, based on Dutch synonyms for dizziness.<sup>4</sup> We manually reviewed the full-text medical records of identified patients and included all patients aged ≥65 years with a new episode of dizziness. In order to select only patients with non-vestibular dizziness, we excluded dizzy patients with GP diagnosis vertiginous syndrome, labyrinthitis, Ménière's disease, vestibulitis, and benign paroxysmal positional vertigo. For group comparisons we used the  $\chi^2$  test, logistic regression analysis, and multilevel analysis (to adjust for the categorical variable 'general practice').

Of 50 601 patients aged ≥65 years, we identified 1640 older patients with a new episode of non-vestibular dizziness (mean

age 75.4 years ± 7.1; 64.3% female). Of these, 151 (9.2%) received a prescription for AVDs from their GP during the first consultation in this episode. GPs most frequently prescribed betahistine (54%), followed by cinnarizine (44%), and other AVDs (2%). Prescription of AVDs by GPs for patients with a new episode of non-vestibular dizziness was independently associated with the presented symptoms 'spinning sensation' and 'loss of equilibrium', whereas not prescribing AVDs was independently associated with the presented symptom 'near faint' (Table 1).

Despite the absent evidence for the effectiveness of AVDs for non-vestibular dizziness, GPs prescribed AVDs during the first consultation in 9.2% of older patients with non-vestibular dizziness. Although this is not exceptionally high (Bregnhøj reported prescribing of ineffective medication in 6% of all GP prescriptions<sup>5</sup>), AVDs may cause serious side effects, like dystonia and parkinsonism.<sup>6,7</sup> Next to this, prescribing ineffective drugs may distract from the preferred approach of non-vestibular dizziness in older patients: a systematic exploration of possible contributory causes of dizziness that are amenable to treatment.<sup>8</sup> Reasons for irrational prescribing of AVDs may be the perceived medical need of the patient, patients' expectations, or doctor's (incorrect) perceptions of patients' expectations.<sup>9</sup> However, the results of our regression analysis also suggest another explanation: immediate drug prescribing as

a clinical reflex ('looks vestibular').

Despite the absent evidence, GPs prescribe AVDs for older patients with non-vestibular dizziness. This should be discouraged, as AVDs may have side effects and prescribing ineffective drugs may distract from another, more preferred, approach of dizziness in older patients.

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DOI: 10.3399/bjgp12X656757

## One-dimensional learning: detrimental to the Situational Judgement Test?

Medical students acquire knowledge, apply theory, and develop skills during their undergraduate training. At medical school, formal teaching sessions tend to focus on the communication between doctor and patient, often with only passing reference to more complex everyday scenarios in which doctors find themselves. There are many situations and diverse interactions demanding effective communication in which the future clinician may be undertrained. These could be with, but are not limited to, members of the patient's family or other healthcare professionals and through different media such as by telephone, email, or with legal personnel. The nature of medical training regarding communication is too one-dimensional. The importance of multiprofessional teamwork is emphasised throughout our training, but opportunities to consolidate this theory in real-life scenarios are all too rare. As a newly qualified doctor or when later holding a position of increased responsibility, a lack of experience of real-life professional interactions may contribute to difficulties with colleagues and lead to increased stress in the workplace. For example it would be helpful to provide strategies for confrontation resolution when in challenging situations. At the other end of the spectrum, introducing students to the art of communicating a referral to another healthcare professional would be beneficial. The focus during training needs to broaden.

Difficult decisions may have to be made in parallel with communicating in unfamiliar settings. Thus the lack of experience of communicating in these situations may affect the development of clinical decision-making skills; skills that are indispensable to a competent clinician. For instance, when faced with the uncertainty that often permeates general practice, it is imperative to both arrive at and communicate a well-

reasoned, decisive plan of action. This can be complicated further if the setting of the communication is foreign to the clinician. GPs familiar with personal and emotional experiences of these situations will be better equipped to deal with the challenges posed by time, language, cultural, and sensitive issues, and the patient's agenda, while still establishing rapport and trust. The lack of exposure to such scenarios, whether real life or simulated, will surely be to the detriment of future skills as a clinician and also in the short term potentially, in achievement in the Situational Judgement Test.

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DOI: 10.3399/bjgp12X656766

## Introducing an old teaching tool to general practice

The term 'doctor' comes from Latin for 'to teach'. In general practice, this can involve teaching patients, medical students, trainees and other health professionals. As part of my medical school rotations, I recently shadowed a doctor who was particularly keen to teach both his patients and medical students. I thought his method of drawing out diagrams for patients was particularly helpful to a patients' understanding of what was happening in their bodies. However, when drawing on paper, it is necessary to show the patient what is being drawn in the correct orientation. This involves positioning oneself next to the patient, that can potentially make some patients uncomfortable. This can be compounded by the doctor inviting medical student(s) to also learn from the drawings at the same time as

the patient, creating an unintentional huddle mid-consultation.

I suggest that doctors who are keen to teach in this way consider investing in a whiteboard. Whiteboards have largely replaced traditional chalk and blackboards. Marker pens are used to write on the smooth surfaces of whiteboards, making them easy to erase. A quick search on a popular shopping website revealed that a 60 x 40 centimetre whiteboard could be bought for as little as £5. An investment in a whiteboard may therefore be a way to reduce paper costs in the long term. They may also be more environmentally-friendly than using paper. Importantly, as they can be placed on a part of the wall visible to all, they can be used to teach students and patients simultaneously without unintentional invasion of personal space.

However, careful thought regarding placement of the whiteboard is necessary to avoid introducing a lecturer-student dimension to the already complicated patient-doctor relationship. This may be the case if the doctor has to stand up to write on the board. I suggest placing the board in such a way that the doctor can write on it while sitting down so they remain on the same level as the patient.

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DOI: 10.3399/bjgp12X656775

## Are GPs unsympathetic to infertile women?

Are GPs unsympathetic to infertile women? The National Infertility Awareness Campaign (NIAC) published results from their most recent patient survey on 27th August 2012, based on responses from 456 patients collected in 2011. While 78% of responders indicated their GP was sympathetic and helpful, almost 50% also said they felt their GP lacked the necessary knowledge of infertility and treatment options available to provide an effective service. Clare Lewis-Jones, Chief Executive of NIAC, suggested this could explain why some patients (22%) with fertility issues perceive their GPs as unsympathetic.<sup>1</sup>

Dr Clare Gerada, chair of the Royal