Letters

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Editor's choice

Our role in addressing inequalities

It was fantastic to have an issue devoted to socioeconomic health inequalities; one of the defining issues of our time.[1]

As doctors we have an important role to play in *'... improving and protecting the nation's health and wellbeing, and improving the health of the poorest fastest'*.[2] However, in general practice most of our interventions are aimed at the individual level. Compared with population-level interventions like taxing alcohol, banning trans fats from foods, enforcing smoke-free public places, and promoting healthy urban design, individual-level interventions can actually exacerbate socioeconomic inequalities.

Julian Tudor Hart's inverse care law states that services are used most by those who need them least.[3] Aside from health service utilisation, all interventions that require health literacy or healthy choices tend to widen inequalities. Living in conditions of deprivation imposes a 'poverty tax' that impedes people's ability to align their short-term actions with their long-term interests.

Although it is important that we continue to quantify health inequalities, we need to be careful not to inadvertently promote them by restricting our activities to those that disproportionately benefit the well-off.

GPs have an important role to play in addressing local-level social determinants of health through commissioning, advocacy, and service provision. We look forward to reading more articles on inequalities where the focus is on addressing them at a population level in our daily practice.

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The vanishing skill of watchful waiting

I was glad to read Professor Ogden's thoughtful 'Out of Hours' on 'The vanishing skill of watchful waiting'.[1] Clearly, as the Preacher says (Ecclesiastes 3:1) there is a season for everything; a time to act immediately and a time to 'wait a wee while'. The skill in both the art and science of medicine is in knowing when the one or the other is the more appropriate and safer pathway; not at all an easy decision but surely as important in medical education as the sequencing of genes and the managing of budgets.

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Consultation length

Consultation length in general practice has long been seriously under-researched given its central importance. The key issue is serious, as Orton and colleagues show that longer consultations are significantly more patient centred and beneficial for patients[1] whereas Elmore and colleagues find no benefit in terms of patient experience from longer consultations.[2]

Both studies have the advantage of studying substantial numbers of precisely timed consultations, 440 in Elmore and colleagues and 842 in Orton and colleagues. The latter applied an internationally validated instrument for assessing patient-centredness, whereas Elmore and colleagues had the advantage of obtaining patient responses directly.

A weakness in both studies is that they had relatively few consultations lasting 15 minutes or more; only 74 (16.8%) in Elmore and colleagues and 50 (6.1%) in Orton and colleagues. Benefit for patients is likely to be optimised when patients know that they will receive at least 15 minutes and then on average do so, which applied in neither study.

Elmore and colleagues studied practices *'... below the 25th percentile for mean communication score in the 2009–2010 survey, adjusted for patient case mix'*. This group selected for relatively poor communicators probably lacked the consulting skills to give patients a good experience, even with more time. This important limitation was clearly stated in the full version, but did not appear in the two-page printed summary of the article.

We do not believe that results from GPs selected on the grounds of being poor communicators can be generalised. An absence of evidence does not indicate evidence of absence.

Meanwhile, decisions must be taken by managing partners about how long on average patients' appointments should be. We confirm that in our two very different research general practices patients receive on average 15 minutes or more (mean 16.1 minutes in St Leonard's). Further research on consultation length is urgently needed.

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Consultation length: author response to Dr Brian Goss

Thank you for your response.[1] Consultation length was, as you suggest, observed rather than imposed. We were careful not to imply causality. As you rightly suggest, we cannot do so from observational data alone. We concluded that we found no correlational relationship between length of consultation and patient experience or patient satisfaction.[2,3] In our closing remarks in the full article, we suggest that:

'Some consultations may be appropriately short, with both doctor's and patient's agenda effectively addressed, for example, where the doctor is dealing with a simple administrative issue or following up a problem with a patient whom they know well.' [4]

This appears to be the conclusion you have also come to in your letter. We note in the full paper that a lack of evidence of an effect is not necessarily a lack of effect, and we do not want to suggest that consultation length should be made shorter or is not important for other areas of clinical practice.

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Consultation length: author response to Dr Brigid Joughin

Thank you for your response.[1] We were also surprised at the lack of correlation between consultation and patient experience and patient satisfaction. In reference to your first point, the national GP–patient survey questionnaire communication items that we used in the study ask the patient specifically about whether they feel they had enough time in the consultation.[2] We conducted separate analyses to investigate whether there was any relationship between this item and consultation length, and found no evidence of an effect. There has been some interesting work conducted about patient perceptions of time in general practice by Ogden and colleagues.[3] She found that, overall, patients tended to underestimate the time spent with their doctor. She also measured the preferred time post-consultation and found that patients would have preferred longer with their GP. We agree it would be interesting to study patients' estimations of how much time they think they will need before the consultation.

With regards to your second point, we suspect you are correct in your hypothesis that there may be a stronger correlation. Unfortunately this is not something we measured as part of this study, although we did ask GPs to complete the same communication scale as patients and compared ratings of GPs and patients in the same consultation. We will be reporting these findings in a separate article.