RNZCGP DIGEST

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

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IN THIS ISSUE

Welcome to the RNZCGP digest. The digest contains a selection of recent New Zealand and overseas journal articles and other publications that might be of interest to general practice and to those working in the primary care sector. Some of the articles are available in full at the links provided. Others require an online subscription.

Health workforce

Approved CME activity
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Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14

Authors: Hobbs F, Bankhead C, Mukhtar M, et al.

Seeking to address the lack of objective data on the volume and nature of primary care activity, the authors studied data on over 100 million GP and practice nurse consultations over the seven years to March 2014. Data were sourced from the Clinical Practice Research Datalink database and covered 398 of the 674 English general practices for which data were available.

Key results included:

- GP and practice nurse consultation rates (combined) increased by 10.5% over the seven years.
- Age and sex standardised consultation rates increased by 9.1%.
- For all consultations with GPs, adjusted rates increased by 12.36% over the seven years.
- Adjusted rates of surgery consultations with GPs increased by 5.2% and GP telephone consultations increased by 99.6%.
- For nurses, surgery consultations remained stable and telephone consultation rates showed a slight decrease.
- Over this time the duration of GP consultations increased by 6.7% from a mean of 8.65 to 9.22 minutes.

Between 2007 and 2014 there was a 1% decrease in the number of full-time equivalent GPs per 100,000 patients. Consultation rates per practitioner show workload changes over and above any extra demand from population growth. The 12.4% increase in GP consultation rates linked to the 4% rise in mean consultation duration show that GP direct clinical workload has risen by 18.2% in seven years.

The authors comment that the use of telephone triage as a strategy for coping with rising workload has been widely deployed, but found it does not reduce overall workload due to the time involved in telephone calls and the proportion of calls resulting in a subsequent surgery consultation.

Hobbs et al. conclude that their findings show that perceptions of rapidly rising workload in English general practice are well founded. They suggest that the system seems to be approaching saturation and GPs are now unable to accommodate consultations longer than the allotted appointment slot by balancing them with shorter consultations.

Reference: Lancet. 2016 Apr. doi: http://dx.doi.org/10.1016/S0140-6736(16)00620-6

Quality improvement

Provision of social norm feedback to high prescribers of antibiotics in general practice: a pragmatic national randomised controlled trial

Authors: Hallsworth M, Chadborn T, Sallis A, et al.

Antimicrobial resistance is a well-recognised threat to public health for which clinically unnecessary prescribing of antibiotics in primary care is an identified driver. This well-designed *Lancet* trial, based in England, aimed to evaluate feedback intervention, patient-focused information, and a combination of both as methods for reducing unnecessary antibiotic prescribing. Social norm feedback – where participants are presented with information to show that they are outliers in their behaviour – has been shown to affect recipients who adjust behaviours towards the social norm.

For the first intervention, clinicians were provided with prescribing data and personalised feedback in a letter from England's Chief Medical Officer and an information leaflet.

The second intervention was patient focused. Practices were provided with resources to communicate the message that unnecessary antibiotic use is linked to future personal consequences arising from antimicrobial resistance. This intervention was intended to reduce real or perceived pressure from patients.

The trial involved 1581 randomly selected eligible practices. GPs were unknowingly assigned to the control group (no intervention) or the first intervention group. The practices were then re-randomised for the second intervention, creating two additional trial groups: GPs who received the second intervention only, and GPs who received both interventions.

Practices' prescribing data was monitored before, during, and after the interventions. Researchers found that mail-based social norm feedback to clinicians with high antibiotic use was low cost, scalable and effective over a six-month period compared to the control group. The group that received both interventions also had an overall lower prescribing rate than the control group. Interestingly, the patient-based intervention produced a brief but not sustained increase in prescribing.

Overall, personalised social norm feedback shows promise as an intervention to reduce unnecessary antibiotic prescribing.

Reference: Lancet. 2016 Feb. doi: http://dx.doi.org/10.1016/S0140-6736(16)00215-4

Clinical issues

Overdiagnosis and overtreatment: generalists – it's time for a grassroots revolution

Authors: Treadwell J, McCartney M.

This editorial looks at the important role that generalists play in preventing overdiagnosis and overtreatment. The authors note that the drivers for clinical practice tend to originate from specialist research. Specialists with responsibility for one condition may not have the generalist, holistic overview needed to help patients sort valuable interventions from low-value ones.

Drivers of overdiagnosis are well described: advancing technology allows detection at earlier stages or 'pre-disease' states, well-intentioned enthusiasm and vested interests combine to lower treatment and intervention thresholds, and fear of medicolegal action and payment and performance indicators reward overactivity. This leads to treatment harms and a waste of resources.

In announcing its most recent lipid guidelines, the National Institute for Health and Care Excellence (NICE) estimated that if everyone eligible took treatment, then 28,000 heart attacks, 16,000 strokes and 8000 deaths would be prevented over three years. The authors note that another outcome would be that 4,448,000 patients would be given statins for no benefit.

GPs not only see the consequences of over-medicalisation, but also carry the extra workload caused by it and will benefit from reducing overdiagnosis and overtreatment. They will be able to redistribute their time away from low-value interventions and towards high-value interventions, enjoy more fulfilling work, and reclaim their role as expert generalists.

Clinical issues

The authors call on the makers of guidelines to ensure that grassroots GPs, with such a valuable, broad perspective, are enabled to have a greater influence in their production. 'Ordinary' GPs are valuable GPs, they state, and call on GPs who might think that their voice is not important to get involved in shaping the future of clinical practice for their patients and themselves.

Reference: Br J Gen Pract. 2016 Mar;66(644):116-7. doi: 10.3399/bjgp16X683881

Serologic testing in celiac disease: practical guide for clinicians

Authors: Rashid M, Lee J.

Coeliac disease (CD) is a common, chronic gastrointestinal disorder in which ingestion of gluten leads to villous atrophy of the small intestine by an immune-mediated mechanism in genetically susceptible individuals. The disorder has lifelong implications (strict gluten-free diet) and, if left untreated, can lead to complications such as the development of other autoimmune disorders. This article reviews the currently available serologic tests, endoscopic small intestinal biopsy and HLA testing for CD, and identifies various indications and pitfalls. Notably, the reviewed CD guidelines are mainly aimed at gastroenterologists, despite primary care physicians being frequently involved in the initial differential diagnosis.

The authors advocate for a high index of suspicion of CD, and discuss its broad clinical spectrum, noting four broad patterns: classical CD, non-classical CD, subclinical CD, and potential (latent) CD. Five antibody tests are described and compared, concluding with a preference for IgA-based tests for screening due to their higher sensitivity; in particular the IgA tTG antibody test. For children under two years, testing with DGP antibody (IgA and IgG) along with the IgA tTG antibody is recommended. The authors also recommend testing serum IgA levels, as patients with CD are 5–10 times more likely to have selective IgA deficiency.

Notably, antibody tests are not generally considered sufficient to confirm diagnoses, and the authors recommend referral for those with positive tests for endoscopic small intestinal biopsies. Criteria are provided for those for whom a small intestinal biopsy is unnecessary. Human Leukocyte antigen (HLA) testing – specifically for HLA-DQ2 and HLA-DQ8 heterodimers – is advised to exclude or help confirm a CD diagnosis.

Finally, the impact of a gluten-free diet (GFD) on serologic testing is discussed, with authors stating that a GFD should not be started before confirming a CD diagnosis. Feeling better on a GFD does not imply CD, although it is notably common for patients to start this diet on their own. This is an additional reason why serology and biopsy are necessary to distinguish CD from non-coeliac gluten sensitivity.

Reference: Can Fam Physician. 2016 Jan;62(1):38–43

Health IT

Telephone triage systems in UK general practice: analysis of consultation duration during the index day in a pragmatic randomised controlled trial

Authors: Holt TA, Fletcher E, Warren F, et al.

Telephone triage, where a patient requesting an appointment is first offered a callback from a doctor or nurse, is increasingly used in UK general practice to manage demand for urgent GP care. During triage, the need for an appointment is assessed and a management plan is agreed, including a face-to-face follow-up consultation where appropriate. This study looks at whether telephone triage reduces clinician–patient contact time on the day of appointment request compared with usual care. The study uses data from the ESTEEM trial, which enrolled 20,990 patients requesting a same-day appointment with a GP registered with 42 practices in England. Practices were randomly allocated to provide GP-led triage, nurse-led triage (with decision support software), or usual care. The ESTEEM trial found that triaged patients were more likely to require further consultations over the subsequent 28 days, with no improvement in overall health economic costs.

The study suggests no overall clinician time saved with telephone triage. The researchers conclude that telephone triage, whether undertaken by a doctor or a nurse, appears not to offer added efficiency than usual care. Nurse-led triage, with the aid of decision support software, is associated with a reduction in overall GP contact time on the day of appointment request, even though overall clinician contact time is increased compared with usual care.

Reference: Br J Gen Pract. 2016 Mar;66(644):e214–8. doi: 10.3399/bjgp16X684001.

Cross-cultural care

Consultations conducted in languages other than English in Australian general practice

FREE

Authors: Bayram C, Ryan R, Harrison C, et al.

Appropriate use of professional interpreters is associated with improved clinical care, access to care, outcomes, and satisfaction with care. However, there is concern that they are underutilised in general practice. This study sought to determine the need for, and use of, professional interpreters in general practice. It was a sub-study of the Bettering the Evaluation and Care of Health (BEACH) programme (a continuous, national, cross-sectional survey of Australian GP activity). Data were provided by 206 randomly sampled GPs between December 2013 and March 2014.

Of 6074 patients at GP consultations, 16% spoke a language other than English (LOTE) at home. Five percent of all GP consultations involved communicating in a LOTE. Of these, 1% involved professional interpreters, 82% were conducted by multilingual GPs who spoke the patient's language, and 18% involved a family member or friend. GPs felt the use of a professional interpreter would/may have improved the quality of 28% of these consultations.

The authors say that the reliance on multilingual GPs is concerning because they are unlikely to be able to cover the diversity of languages spoken in Australia. The authors also highlight the risks associated with using family members/friends as interpreters, including serious adverse health outcomes (including death), and medicolegal, privacy and ethical concerns. They recommend caution for GPs using family members/friends as interpreters. The authors conclude that their study confirms the use of professional interpreters at LOTE consultations is rare in Australian general practice. GPs see the opportunity to improve the quality of LOTE consultations by using professional interpreters to replace family member/friend interpreters, and this group should be targeted in future practice-based interventions that aim to increase the use of interpreter services.

Reference: Aust Fam Physician. 2016 Jan–Feb;45(1):9–13.

Comment: Right 5(1) of the New Zealand Code of Health and Disability Services Consumers' Rights states: "Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter." HDC explains that the test for whether the provider has met the Code's obligation to provide interpreter assistance will depend on whether the provider took reasonable steps to facilitate the best interpreter services available in the circumstances.

Further information:

How to use interpreters in general practice: the development of a New Zealand toolkit – Gray B, Hilder J, Stubbe M. J Prim Health Care. 2012;4(1):52–61.

Language Line – a telephone interpreting service in New Zealand

Medicolegal and ethical issues

Ethical considerations in recruiting primary care patients to research studies

FREE

Authors: Barton C, Tam C, Abbott P et al.

Research findings are frequently difficult to translate into a primary care setting, which makes research that is based in primary care, with study subjects recruited from this setting, all the more important. This Australian article considers common ethical issues that researchers face when recruiting patients from primary care settings. In primary care research, the common issues are patient privacy and gaining informed, voluntary consent. The procedures used to recruit participants should be consistent with the core ethical values of merit and integrity, respect, justice, and beneficence. In Australia, the National Health and Medical Research Council's (NHMRC's) National Statement on Ethical Conduct in Human Research (the Statement) must be used to inform human research that is funded by, or takes place under the auspices of, any of the major research and academic institutions.

The authors explain that recruiting patients in general practice will nearly always require review by an ethics committee. The involvement of clinical staff in the selection of participants can raise ethical issues relating to patient privacy. Further, if the person recruiting the patients is also the treating GP, issues arise about gaining informed consent and voluntary participation when there is a power difference between the patient and doctor.

A common, acceptable practice among primary care researchers is, following agreement from the participating practice or GP, to provide the selection criteria to practice staff who will then identify patients from clinical records. The participating GP then makes these patients aware of the research and invites them to take part. The patients contact the researchers to register their interest or enrol in the study. The authors explain that privacy and confidentiality should also be considered when reporting results using small samples or samples drawn from small towns. Further, the use of incentives as part of the recruitment strategy remains contentious in research. The authors conclude that Australian researchers should review the Statement and Australian privacy laws and principles to ensure recruitment into research meets contemporary ethical standards prior to submitting a study protocol for ethical review.

Reference: Aust Fam Physician. 2016 Mar;45(3):144–8.

Comment: In New Zealand, the National Ethics Advisory Committee's **ethical guidelines for health and disability research** (interventional studies and observational studies) set out the established ethical standards that all researchers must meet when undertaking health and disability research, whether or not that research requires health and disability ethics committee review.

Access to care

General practice encounters with men

FREE

Authors: Bayram C, Valenti L, Britt H.

This research looked at the use of GP services by Australian men of different age groups and the types of problems managed. It aimed to determine whether any patterns had changed since the research of 1999–2000. The researchers analysed GP encounters with male patients from data collected in the Bettering the Evaluation and Care of Health (BEACH) programme from April 2014 to March 2015. Data about patients' regular general practice (June to September 2013) from a supplementary analysis of nominated data (SAND) sub-study, Medicare claims data, and Australian Bureau of Statistics population data were also gathered. The study found that males in the Australian population were less likely to see a GP at least once than females (80% vs 88%) in 2013–2014. Males also had a lower average annual number of GP consultations per head of population than females (4.6 vs 6.1). While attendance patterns were similar for male and female children, the researchers noted particular differences in the 15–44 year age group, where only 71% of men attended at least once and visited an average 3.1 times per head of population that year.

Of the 7799 patients sampled in the SAND sub-study, men aged 15–44 years were significantly less likely to have a regular practice than women aged 15–44 (87.3% vs 94.3%). In 2014–15, 42.9% of all encounters were with male patients. Furthermore, male patients aged 15–44 years were significantly more likely to be new to the practice (12.2%), and had high rates of new problems managed at encounters (64.9 per 100 encounters). Overall, respiratory, psychological and musculoskeletal problems were more commonly managed

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in young men, whereas circulatory and endocrine/metabolic problems were more common among older men.

The authors conclude that sex-specific changes in GP service use occur during adolescence, consistent with previous studies. They suggest that GPs should be mindful that young men might not have established an ongoing relationship with a GP or practice. Therefore, encouraging such a relationship would support continuity of care, disclosure of sensitive information, and optimal health outcomes. Furthermore, they say that male-specific problems accounted for only a small proportion of all problems dealt with in men in general practice. As such, they recommend taking a holistic approach to men's health, particularly in young men who may miss out on the benefits (eg prevention, continuity of care, and early diagnosis of disease) associated with a having a regular practice.

Reference: Aust Fam Physician. 2016;45(4):171–4.

Public health

Social accountability at the micro level

Authors: Goel R, Buchman S. Meili R, et al.

General practitioners see patients in the full context of their lives, and so are able to understand how social determinants (ie biological, socioeconomic, psychosocial, behavioural or social factors) affect and support their health. In this commentary, the authors explore how interventions to improve the social determinants of health can be applied at the individual 'micro' level by general practice teams. It suggests a piecemeal, ongoing exploration of patients' lives by various members of the general practice team, to provide a (recorded) more complete picture of the various elements that may be impacting on their health. The authors suggest that GP team members assess:

- identity and demographic characteristics: age, ethnicity, religion, indigenous status, language preference, sex, gender identity, sexual orientation, and presence of physical or mental disabilities.
- income, ie to indicate potential barriers to care and services and health-determining factors (eg food security)
- education and employment, particularly literacy
- prescription drug coverage
- housing, including who and how many people they live with, safety, exposure to pests, the state of repair, and relationship with the landlords
- social supports, ie services, family, friends, neighbours, and communities
- mental illness, substance use, and trauma, including former experiences and family history.

The author uses the case of Diana, age 40, with a recent diagnosis of cervical cancer, as an example of how using this approach can improve health outcomes in ways that family doctors cannot provide through medical care alone. As noted, the tools and interventions may initially seem like the "straws that will break a busy practitioner's back"; however, the time and effort commitment can be distributed, and the authors argue that positive effects will outweigh the work/time commitment.

Reference: Can Fam Physician. 2016 Apr; 62(4): 287–290.

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