Engaging patients with psychosis in consultations

Design of study has several problems

EDITOR—McCabe et al discussed how psychiatrists engage with psychotic patients during routine consultations.¹ However, the design of their study may have compromised the conclusions.

The clients selected were already attending a psychiatric outpatient clinic and had willingly agreed to participate in the study. These clients presumably had already engaged with their respective teams, which affects the generalisability of the study to clients who do not engage.

Videotaping the consultation introduces an element of subject and observer bias. The presence of a video camera can affect the nature of the interaction between doctor and client, which again affects the generalisability of the findings to routine clinical consultations. Given that 50% of the clients were not white British, the social interaction may have been influenced by the social, ethnic, and cultural differences between the client and doctor. In addition, clients with psychosis often present with thought disorder, negative symptoms (poverty of thought), and other abnormalities of affect, which makes the interaction qualitatively and quantitatively different from normal conversation.

Some studies have shown that patient centred skills, particularly when giving information and counselling, are related to increased compliance with treatment, improved satisfaction, and decreased symptoms and emotional distress.² Unfortunately these studies occurred in primary care and may not be applicable to psychiatric consultations. Clients at different stages of psychotic illness need different types of consultations, with the clinician having to judge the amount of information that would be beneficial for each person.

This article has succeeded in highlighting the importance of the consultation between doctor and patient in engaging clients. However, psychiatric treatment is within a multidisciplinary team, with other agencies being equally capable of delivering information. An average psychiatric consultation lasts only 15 minutes, which makes it quite difficult to conduct a medical review—for example, of symptom control, dosage, and side effects. The purpose of the consultation needs to be clarified to ensure that the consultation is appropriately conducted for maximum benefit to the client and to

avoid duplication of the work done by other agencies.

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To listen or not to listen

EDITOR—The results of the study by McCabe et al, that psychiatrists avoid talking about the content of psychotic symptoms, is in my opinion in complete accordance with everyday practice.¹ It is not the results of the study that I find surprising but the reactions of Rajesh (letter above) and Duffett to these results.² Their reactions are defensive. The video camera is blamed, and weaknesses in the study are pointed out. Clearly one doesn't like to discuss the content of the results.

As a psychiatrist I was trained to listen. But also not to listen. There is little or no place for psychotic content in textbooks. These are thought to be diagnostically of little significance and therapeutically irrelevant. Discussing the content of delusions costs time and has no consequences. Indeed, entering into a discussion about, for example, why nobody believes that the patient is God, might lead to conflict and emotional outburst. So we are trained not to listen and avoid digging into these subjects.

Whether this is a good strategy is questionable. The study by McCabe et al indicates that this common attitude is distressing for patients. They want to discuss items that are central to their experience and of utmost importance to them—and exactly these items are kept out of the conversation.

The recent rise in cognitive behaviour therapy for psychotic symptoms, with very promising results, indicates that taking the contents of psychotic symptoms seriously is not such a bad idea (see the *Cochrane Library*).

My own experience is that taking some time to discuss seriously the content of delusions and the messages that voices bring is highly appreciated by patients—and, believe it or not, often time saving. It taught me a lot about these psychotic experiences that is

found nowhere in psychiatry textbooks. Sometimes fruitful discussions are possible about the realness of these experiences, and the way to deal with them, which has proved to be helpful to patients.

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Cognitive behaviour therapy can help end alienation of psychosis

EDITOR—It comes as no surprise to read that health professionals show discomfort with interactions around the content of psychotic experience beyond its existence as a diagnostic indicator.¹ The difficulty in developing a dialogue reflects a difficulty in making sense of psychotic patients' communications.

This underlies the prejudice with which society as a whole treats people with psychosis. Traditional psychiatric teaching tells us that these phenomena lack understandability and that there is no point attempting to engage in a discussion about them. Consequently the people with such experiences are qualitatively different, and much biological research has set out to prove this. Health services thus unwittingly collude with maintaining the prejudice that blights the lives of people with psychosis.

Yet much evidence exists that the experiences of people with psychosis are entirely understandable. Since 1952 evidence has been available that the therapeutic development of understanding may be achieved using a cognitive behavioural approach.² It is now proposed that a therapist should show clear linkage between personal experience, core beliefs (schemas), and emergence of psychotic symptoms.³ Such developments have been facilitated by the understanding that no qualitative difference exists between psychotic and "normal" experiences.⁴ It is difficult to convey adequately the remoralising effect of developing a meaningful understanding of these phenomena with a patient.

Case study material and data from randomised controlled trials over the past decade provide support for both effectiveness and efficacy. If need is defined as the potential to benefit from the intervention it is enormous among this most vulnerable group of patients. The ability of mental health staff to empathise with patients with

psychosis is also improved with a comparatively small amount of training.⁵ The number of staff, then, with training needs is vast. The development of interest groups shows enthusiasm of staff to work in this way with patients, but despite this service development remains pitiful.

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Authors' reply

EDITOR—Rajesh notes that the people who agreed to participate in our study (and to be videotaped) were already engaged in treatment. This is crucial in contextualising the findings, an issue we raised in our discussion. The nature of patients' symptoms when they are more unwell (such as paranoia and suspiciousness) means that they are less likely to agree to participate in research, particularly with a video camera.

The presence of a camera can obviously influence the subject of observation. However, psychotherapists regularly have their practice recorded, and experience implies that people get used to cameras quickly. Although this is an undesirable limitation, there is no evidence that it invalidates the findings.

With respect to the social and ethnic diversity of the participants, we consider this a strength rather than a weakness because despite these differences the observations were consistent across consultations.

Rajesh also questions whether outpatient psychiatric consultations are the right place for the content of psychotic symptoms to be discussed. We wonder when the right occasion is and to whom patients should talk about their psychotic symptoms if not their psychiatrist. Patients did use it as a place to raise the content of their symptoms. This led to considerable interactional tension, especially in consultations with distressed patients who had symptoms. Initial analyses of repeat consultations (not presented) indicate that it was less common when patients had fewer symptoms at follow up appointments.

This is precisely the challenge of communicating with psychotic patients: when patients are less psychotic communicating with them is easier, and when they are more psychotic successful communication becomes more difficult and engagement becomes particularly important.

Avoiding sources of disagreement may be a useful strategy and facilitate successful communication about other business such as compliance with drug treatment. However, clinicians' willingness to participate in a conversation about the content of patients' thoughts and experiences and their emotional distress (as van Meer and Moorhead note is integral to cognitive behaviour therapy) may make it easier for patients to engage with clinicians precisely when they are psychotic.

We talk about patient engagement with services and how certain patients are difficult to engage, yet in one to one interaction with patients, clinicians either regard proactive engagement with important patient concerns as inappropriate or are not sure how to go about it. The effective delivery of interventions in mental health care relies on identifying mechanisms of successful engagement at this core level of interaction between doctor and patient.

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Some screening is necessary to identify excessive drinkers early in primary care

EDITOR—In his comments on the paper by Beich et al, Rollnick refers to "a seemingly flat refusal from a group of leading European alcohol researchers to accept the validity of a qualitative study that reported concerns expressed by practitioners."^{1,2} As the researchers in question and as members of the WHO Phase IV Research Group (collaborative project on identification and management of alcohol-related problems in primary health care) whose work was referred to by Beich et al, we here clarify our previous response on *bmj.com*.³

What we saw as particularly unhelpful about the Beich et al paper was its conclusion that screening for excessive alcohol consumption creates more problems than it solves and should therefore presumably be abandoned. We think this conclusion unjustified, mainly because the general practitioners whose views on screening were reported had taken part in a randomised controlled trial of brief intervention. This must have affected their judgments and rendered them unrepresentative of general practitioners in general, among whom implementation of brief interventions is being encouraged.

We agree that general practitioners' experiences are important. An essential part of the work of the WHO phase IV study is to use focus groups and other qualitative methods to elicit these experiences before implementation is attempted. Results emerging from some participating countries describe ways in which screening can be made more acceptable to health profession-

als and patients alike by targeting it at specific types of consultation. However, Beich et al's proposal that general practitioners should be advised to restrict alcohol interventions to patients in whom "signs of alcohol playing a negative role in a case history [are] present"⁴ undermines the aim of early identification, thus returning us to the practice of considering intervention only when it was already too late to prevent harm.

We know that the article by Beich et al has had damaging effects on plans to implement brief alcohol interventions in primary health care in several parts of the United Kingdom and elsewhere. We see this as detrimental to both public health and patient welfare and hope that this letter, and the associated correspondence on *bmj.com*, can in some measure help to reverse it.

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Current medical treatment for tuberculosis

Aspects of chemotherapy and management need clarifying

EDITOR—We take issue with some of the comments made by Chan and Iseman in their clinical review of current medical treatment for tuberculosis.¹ These points have already been covered in the evidence based guidelines on both the chemotherapy and management and the control and prevention of tuberculosis by the Joint Tuberculosis Committee of the British Thoracic Society, but we believe that they bear restatement.^{2,3}

Supplementation with pyridoxine (up to 50 mg/day) as routine—Peripheral neuropathy from isoniazid is very uncommon. Pyridoxine is appropriate for patients at increased risk of peripheral neuropathy.² However, pyridoxine antagonises isoniazid on a milligram for milligram basis. Studies have shown that only 6 mg/day prevents peripheral neuropathy, so only 10 mg (the smallest

tablet size available) should be used, if indicated.

Routine liver function monitoring—Detailed advice on liver function monitoring has been given and is incorporated in the 1998 code of practice,^{2,4} but regular liver function measurements are not required in patients with normal pre-treatment liver function, unless symptoms, in an informed patient, suggest hepatic upset.

Monthly visual acuity checks of patients taking ethambutol—Ocular toxicity is extremely rare in patients with normal visual acuity (Snellen chart) and renal function who are taking an ethambutol dose of 15 mg/kg, and there is no evidence that regular ocular checks prevent events.⁵ Detailed advice is again incorporated in the 1998 treatment guidelines.²

Negative pressure isolation for all suspected or confirmed cases of tuberculosis admitted to hospital—Of the 7300 patients with tuberculosis in England and Wales, some 4000 are culture confirmed; of these 1.3% have multi-drug resistant tuberculosis (Scotland 0.3%, Northern Ireland 0). A detailed algorithm is given in the 2000 code of practice,³ with risk stratification for the patient, type of ward or room used, and risk of multidrug resistant tuberculosis.

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More weight was given to observational studies than randomised controlled trials

EDITOR—Chan and Iseman review several aspects of the treatment of tuberculosis.¹ I was surprised, however, by their claim that directly observed treatment is an effective means of ensuring completion of treatment.

They even illustrate this assertion in figure 2, where they compare completion rates for patients whose treatment is directly observed and those whose treatment is not supervised. They do not say that this is based purely on observational data.² Although the review from which these figures were taken included several randomised controlled trials,

none of the trials evaluated the effectiveness of directly observed treatment and non-supervised treatment—they compared various types of directly observed treatment.

Since the review was published, randomised controlled trials of directly observed versus non-supervised treatment have been done and assessed in a systematic review.³ The conclusion is not in favour of believing in the effectiveness of directly observed treatment. This evidence must be taken seriously into consideration when making a statement on whether directly observed treatment is effective.

This seems to be yet another example of the tendency to overestimate the effectiveness of an intervention when relying on observational studies.⁴

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Authors' reply

EDITOR—Ormerod et al make several important points.

Isoniazid neuritis is rare with adequate nutrition. But tuberculosis increasingly affects immigrants, alcoholics, substance misusers, and people with AIDS, in whom adequate nutrition cannot be assumed.

Excessive doses of pyridoxine can interfere with isoniazid, and 10 mg is an adequate daily dose. Unfortunately, smaller doses of pyridoxine are not consistently available, and doses up to 50 mg daily can be given safely.

Monitoring liver function during chemotherapy is not of proved utility; generally, symptomatic monitoring can detect early hepatitis and prevent fatal liver damage. Self monitoring for the groups above, in whom communication may not be reliable, is problematic. Hence biochemical monitoring remains an appropriate tool. An advantage of directly observed treatment (see below) is regular surveillance for drug toxicity.

Optic neuritis from ethambutol is rare with normal renal function and a dose of 15 mg/kg. The assertion that regular monitoring does not prevent events is, however, potentially misleading. Although neuritis may not be averted, early recognition can lessen the ultimate degree of impairment.

Algorithms are helpful but imperfect tools to identify patients with tuberculosis on admission to the hospital. Putting every

suspect in negative pressure rooms is impractical and costly. However, nosocomial transmission in contemporary hospitals that house many immunocompromised patients remains a serious issue. Although perfect compliance may not be achievable, isolation of all likely candidates remains an appropriate goal.

Fretheim questions the utility of directly observed treatment, citing two studies in which such programmes did not perform well. This begs the question of what constitutes directly observed treatment. Adaptations to local conditions and adequate resources are essential to make this strategy work: it is not an automatic panacea. So long as non-adherence is the major impediment to effective treatment, directly observed treatment will remain a central strategic response.

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Resources used for screening could be spent more usefully elsewhere

EDITOR—Chan and Iseman in their clinical review referred to the global resurgence of tuberculosis and the increase in case rates seen in North America and western Europe over the past decade.¹ Two causes mentioned for these increased rates are immigration and coinfection with HIV.

Both these factors apply in Croydon, south east England, where we have seen changing patterns of immigration with many refugees and asylum seekers arriving from countries with high incidences of tuberculosis. This has coincided with a 100% increase in notifications over the past 11 years, with an estimated HIV seroprevalence of 4.3% in new entrants.² Screening all new entrants from countries with high incidences of tuberculosis is recommended.³ However, no evidence shows that such screening is effective in areas with a mobile new entrant population.

We have set up a clinic for new entrants in Croydon, many of whom are not notified through the port of arrival system. This is a holistic clinic providing tuberculosis screening while also offering help with wider needs such as housing issues, finding schools, and registering with general practitioners. We have diagnosed only three cases of active tuberculosis (table). The patients had mild or no symptoms and were not infectious. Over the same period of time, some 110 cases of active tuberculosis were diagnosed in symptomatic new entrants presenting either through emergency departments or

New entrants screened for tuberculosis in
Croydon, January 1999–November 2002

	No of patients
Screened in clinic for new entrants	2855
Tuberculosis diagnosed	3
BCG given	93
Chemoprophylaxis given	58

referred by general practitioners. Most were not known to the appropriate authorities and had therefore not been screened.

The considerable resources required for screening new entrants would be better spent on ensuring that all new entrants have rapid and easy access to primary care for assessment of all health needs, with a fast track referral system to local chest clinics for patients with suspected tuberculosis. Screening the children of new entrants should continue as people under 16 years benefit most from BCG and antituberculosis chemotherapy.

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Meningoencephalitis due to primary HIV infection

HIV infection may also cause rash or glandular fever type illness

EDITOR—Newton et al describe how meningoencephalitis was caused by primary HIV infection, and we agree with them that a high index of suspicion is required for diagnosis.¹ A more common presentation in unconfused patients is a maculopapular rash or a glandular fever type illness, which provides an opportunity for early counselling and HIV testing without ethical constraints.^{1,2} In south London we recently showed that primary HIV infection remains undiagnosed in patients with a rash or a glandular fever type illness caused by HIV.

Between May 1998 and April 1999, with ethics approval, we retrospectively and anonymously tested 268 stored serum samples for HIV. The samples had been sent to the virology laboratory at St Thomas's Hospital and were from patients aged 16 years and over who had clinical details of a maculopapular rash or fever, sore throat, and lymphadenopathy. Patients with other diagnoses and previous positive results on HIV testing were excluded. Patient confidentiality was maintained by unlinking clinical details from name, hospital, and laboratory numbers.

Of the 268 serum samples tested, eight (3%) were positive for HIV antibody and six (2%) gave results consistent with long standing infection. Two samples (1%) had Western blot profiles compatible with primary HIV infection. HIV RNA was not detectable by nucleic acid sequence based amplification (NASBA, Organon-Teknika) in the samples without HIV antibodies.

Being able to diagnose primary HIV infection provides an opportunity to pre-

vent the spread of HIV when patients are highly infectious, start prophylaxis against opportunistic infection, and start treatment with highly active antiretroviral therapy (HAART) before the immune system is irreparably damaged. Like Newton et al, we believe that more risk assessments and HIV testing is required if patients living in areas such as south London are to receive early diagnosis and benefit from current and future treatments.

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Exceptionalism extends to all "serious infectious diseases"

EDITOR—Doctors reading Newton et al's paper on meningoencephalitis due to primary HIV infection may not realise that any febrile patients with altered consciousness fall within the rules of exceptionalism because they might have a serious infectious disease (not HIV infection alone).¹ Remote-ness from the acute doctor-patient interface, and the meaningless notion of fully informed patient consent being an achievable target, must have clouded the judgment of the General Medical Council when it extended the principles of HIV exceptionalism to all "serious infectious diseases."²

The counselling/consent strictures of exceptionalism have prevented effective control of the spread of HIV infections and promoted unlinked anonymous testing—an ethically disgraceful concept whereby neither patients testing positive nor their doctors can be told that they are infected. See, for example, that 3% of samples tested positive for HIV in the letter by Melzer et al (above).

Breaking nearly every scientific and common sense tenet of infectious disease control, public health management of HIV has for 15 years been dictated by politicians, lawyers, human rights organisations, and, not least, by the UNAIDS organisation in its advice to legislators.³

In an allegedly scientific era of so called evidence based medicine, why has exceptionalism, despite protest from senior experienced clinicians,⁴ spread to embrace all serious infectious diseases? Leaders of our medical organisations should not allow informed consent to interfere with clinical management of infectious disease or seriously ill patients. The general public rightly expects protection from serious infectious disease. The informed consent lobby exhibits uninformed arrogance and paternalism by dictating policies which should be matters of public health and clinical judgment.

The most cogent and compelling indictment of HIV exceptionalism is, that no authoritative clinical trial has covered early diagnosis and treatment after 15 years of modifying drugs being available. Considerations surrounding consent for screening make it almost impossible to mount one. Such matters require urgent national and international publicity and review.

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Care of dying patients

Education in palliative care for all

EDITOR—How sad it is, that in 2003 the simple messages of palliative care have not reached all parts of the healthcare system. Ellershaw and Ward's paper should be a wake up call to the deans of medical and nursing schools and to the royal colleges.¹ No longer is it acceptable to teach surgery and medicine and not include palliative care in the curriculum. The wards of our hospitals are full not only of curably sick people who need care but also of dying people.

All trainees at every level should be able to demonstrate appropriate skills of palliative care in their exams and assessments. Perhaps if the General Medical Council were to drive forward this issue, particularly in training, it would restore some of its credibility and status.

Rabbi Julia Neuberger is wrong when she says that nothing can prepare a young doctor, nurse, or rabbi for facing people whose death is imminent. Training and education can prepare them, while practical experience develops their skills. I reflect on the painful memory of my first breaking of bad news, some 30 years ago. If I had had some basic training it would have been very different.

The goal of all of us should be to ensure that the current and the next generation of healthcare practitioners realise how fundamentally important care of the dying is, at the earliest point in their training.

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Death is not failure but reality

EDITOR—Diagnosing dying is no doubt the first step in achieving a "good death." The success of modern medicine has contributed to prolonging the dying process and in effect is a victim of its own success. Death is

perceived as failure by healthcare workers and is viewed as failure by the general public. Society with its blind faith in medicine has lost touch with dying. Death is no longer perceived as a natural phenomenon. Not too infrequently one comes across the notion of life at any cost.

The proposal to educate generic workers by Ellershaw and Ward is plausible and paramount for the success of palliative care.¹ None the less, the need is pressing to educate society to accept death as a natural phenomenon, without which care of dying patients is doomed to failure.

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State can make drugs available cheaply to poor people

EDITOR—Sri Lanka has shown that the state should try to bring down drug prices in ways other than by asking drug companies to make drugs available at cost price to the poor.¹ The country's state sector (with its zero charge services) has successfully used the concept of an essential drug list for some time, thus curtailing total costs on drugs. Two other lessons from the country apply to retailing.

Firstly, the private retail drug market is poorly controlled as there is no ceiling for prices or on the number of preparations (of the same drug) that can be imported. The government owned State Pharmaceutical Corporation has several retail pharmacies, which sell high quality generic drugs at cheap rates, thereby competing with the private sector. This model can be made more effective by widening the network of outlets nationally.

Secondly, Sri Lankan data show that merely writing generic prescriptions would not suffice because private retail pharmacies dispense higher priced alternatives. We recently sampled 21 private pharmacies for the price of 14 common drugs whose prescriptions had been written using generic terms and compared them with the price from the outlets of the State Pharmaceutical Corporation. The mean cost for drugs from all pharmacies was Rs38.20 (\$0.40; £0.24; €0.36) per day (95% confidence interval 32.90 to 43.50) compared with Rs14.97 per day at the State Pharmaceutical Corporation. One drug was sold at almost three times the cost at the State Pharmaceutical Corporation.

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Competing interests: None declared.

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Inversion of emergency pyramid

Scheme does not address real problems

EDITOR—I do not think the sentiments in the letter by Cooke and Castille reflect the views of most consultants in emergency medicine.¹ The “see and treat” concept was developed at a single hospital and worked well there. It has not been subjected to critical appraisal or peer review.

I have serious concerns that diverting senior clinicians from treating ill patients will be detrimental. It is a waste of years of training and expertise to concentrate the most experienced medical resources of an emergency department on patients who have the least serious conditions—some of whom, one could argue, should not be there at all. I find the term “the faded idea of inappropriate attendance” inappropriate in itself. I think this is an expression of political correctness.

I tested a similar scheme in my own department in 1999, as a run-up to Millennium Eve. I abandoned the idea when I found that I was reassuring a patient that he would come to no harm from a house spider bite while my registrar struggled with the case of a critically ill patient in the resuscitation room, reluctant to disturb the “great experiment.”

NHS Direct, despite its much trumpeted development, has not reduced the numbers of patients attending emergency departments; neither has the opening of walk-in centres—at least not in my area. Emergency departments, in common with the rest of the NHS, remain underresourced, and such schemes as see and treat, while laudable in the big picture, are methods of massaging the figures towards achieving the government's four hour emergency targets without adequately addressing the real problems.

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1 Cooke M, Castille K. Emergency pyramid is inverting already. *BMJ* 2003;326:49. (4 January.)

Inverting pyramids takes time

EDITOR—Cooke and Castille's letter provides a timely update on recent developments in accident and emergency medicine in Britain.¹ However, their comparisons with similar developments in access to primary care are oversimplified.

In primary care most patients are already seen by senior doctors: fully trained general practitioners. Moving to a system providing “advanced access” can therefore be achieved comparatively easily and probably without notable funding implications.

In emergency medicine, on the other hand, most patients are still seen by inexperienced senior house officers. There simply aren't yet sufficient numbers of trained emergency doctors to take on this workload. Those senior emergency doctors currently in post find their time occupied with critically ill patients, together with complex medical and surgical cases. They do not have

the time to deal with “minor” cases as they walk through the door.

The NHS Modernisation Agency needs to realise that there will not be a quick fix solution to emergency care access in this country, at least not without substantial and sustained investment in appropriately trained staff.

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1 Cooke M, Castille K. Emergency pyramid is inverting already. *BMJ* 2003;326:49. (4 January.)

“I wanted a thorough checkup”

EDITOR—Although I work in a general practice that offers good access to its services, some of our patients will still attend one of the local emergency departments to obtain a consultation for a problem that could have been managed in primary care.¹ The patients I have talked to give three main reasons for their actions.

The most common reason is that they wanted “a thorough checkup.” By attending an emergency department, they expect to obtain a lengthy physical examination, followed by a battery of investigations. Invariably, the findings are always normal but, “You never know, Doc, it could have been something serious.”

A second reason is that they wanted a specialist opinion and perceived the quickest way to get this was through an emergency department. This can mean seeing a specialist on the same day for an acute problem or being placed on an outpatient waiting list for a chronic problem: “If I've got a problem with my ear it stands to reason that I should have it sorted out by an ear specialist.”

The third reason they give is that they wanted to be seen at a time convenient for them. This usually means being seen during the evening or at weekends, “So I don't have to take time off work.”

Many doctors would argue that these examples illustrate the need to educate patients to make more “appropriate” use of NHS services. But what happens if patients refuse to use the NHS in a way that doctors (but not the public) see as being appropriate? There are likely to be no easy solutions to meeting rising public expectations, which may eventually lead to the demise of the NHS as we currently know it.

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1 Cooke M, Castille K. Emergency pyramid is inverting already. *BMJ* 2003;326:49. (4 January.)

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