

improvement), and identifies the highest value intervention. We must bear in mind that patient goals may differ from ours, and that the time horizon to benefit of some treatments may be longer than remaining expected life span. Still, we fix what we can.

But it would be naïve to think that suggestions such as Stone's, or mine, go out into a healthcare system inherently eager for improvement. Patients with a long problem list and psychosocial complexity are not popular. In hospitals especially there is a culture of hostility towards them; Stone's mention of 'doctor centred classificatory systems' that brand some as 'heartsink patients' takes a great deal of venom and profanity out of the picture. Institutional counter transference – often tinged with racism, in hospitals with a significant Indigenous clientele – is an obstacle that must be named and challenged if change is to come.

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## The doctor-patient

### Dear Editor

Paul Nisselle's letter about the 'doctor-patient' (*AFP* October 2012) resonated very much with my own experiences of being a doctor-patient.

I had a laparoscopic cholecystectomy performed in 2004. I met my anaesthetist a few minutes before being wheeled into the operating theatre. He asked me what my job was, so I told him. I then informed him of my sensitivity to analgesic side effects. He responded by asking me what type of analgesic I'd like and in what

dose. I had to tell him that was for him to decide!

I also noticed that the patient in the bed next to me, who was also having a laparoscopic cholecystectomy that day, received a reassuring, detailed explanation of what was involved from her nurse, whereas I received no explanation from my nurse. Was this because my nurse knew I was a doctor and should therefore know what to expect? Possibly. Although I did have a different nurse to the patient I was sharing a room with.

Some years later, I had to see a superspecialist who, like Dr Nisselle's ophthalmologist, had to be asked to modify his highly specialised explanation to one that I could understand.

As a result of these experiences, I have asked my GP to write Mrs rather than Dr on future referrals. I wonder if other colleagues have had similar experiences, and if so, whether they too have chosen not to reveal that they are a doctor.

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## Recruitment in general practice

### Dear Editor

General practice is an ideal platform for public health researchers as it provides access to a large proportion of the population and enables researchers to target a range of health conditions. While research in this setting is both valuable and essential, difficulties with practice and practitioner recruitment may hinder the development of evidence in this setting. We read Jones et al's reporting of barriers and enablers to research participation with interest (*AFP* June 2012).<sup>1</sup> This article provides valuable insight to guide researchers in the future design of recruitment procedures in this setting, particularly with the changing demographics of the workforce.

In our experience with recruitment in this setting, we conducted a cross-sectional study, where we sought practice consent to approach patients in the practice waiting room.<sup>2</sup> Despite the known challenges faced in recruitment of practices in this setting, we found little evidence on how to maximise practice consent rate. We employed a number of strategies in line with those recommended by the RACGP.<sup>3</sup>

These included: clinician involvement in study design; financial reimbursements provided to practices; minimising recruitment burden on GPs; minimising complexity of study design; initial telephone contact by lead investigator in the area; and professional development incentives. Our study achieved a 25% practice consent and 75% physician consent rate. Clearly, the recruitment of general practices as research participants is a resource-intensive and challenging process. Researchers using this setting need to take into account these unique barriers while estimating recruitment costs and designing recruitment protocols. While national initiatives exist in the form of the Primary Health Care Research, Evaluation and Development program, further systemic changes to reduce time demands placed on practitioners needs to be implemented in order to increase practice engagement with research.

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