Letters

Abbreviations still spell confusion

Almost four decades ago, we published an article in this journal titled 'Abbreviations can spell confusion'.[1] Generally communication within general practice is good, and if necessary, it is easy to clarify meanings by chatting to the colleague in the office next door. However, communications between the tertiary health sector and primary care are still a problem, despite the availability of rapid messaging systems. A study of inadequate hospital clinical handover from hospital to primary care documented many difficulties.[2] All communications should be timely, accurate and understandable and advise any actions needed for continuing care. While there has been some improvement since the descriptions of Kripalani et al,[3] problems still occur. The use of abbreviations in medicine continues to be a problem in achieving quality patient care.[4]

As an example, here is a summary I recently received describing the continuing care needs for a woman aged 80 years with a scaphoid fracture:

> *'Plan:*
>
> *change to BEFGC*
>
> *opc 5w for cc and rop*
>
> *Safety netted*
>
> *No contact sport or high risk activities for 3 months from injury'*

I circulated the 'Plan' to the 14 doctors in the practice. One colleague suggested that the first line meant 'Big Enthusiastic Friendly Giant Cast'. Only one doctor, who had been an orthopaedics registrar, correctly deciphered the abbreviations ('change to BEFGC': change to below-elbow fibreglass cast; 'opc 5w for cc and rop': outpatient clinic in five weeks for clinical check and removal of plaster). The first two lines confused me; the last was a source of amusement, unless of course the reference to a safety net meant that the hospital considered that she might take up tight-rope walking as a sport.

I have had the privilege of supervising many PhD students, and my advice to them has always been not to use abbreviations. A grumpy examiner faced with unfamiliar abbreviations may just simply fail the candidate.

A recent review suggested that artificial intelligence would improve physician-to-physician communication.[5] However, the introduction to the article gave a list of 24 abbreviations that would appear in the text. Constantly having to refer back to the first page did not speed up communications.

Hospital-to-primary-care communications should be timely and, for accuracy, should not include any abbreviations.

Author

Colin Binns MBBS, MPH, PhD, FRACGP, FAFOEM, FAFPHM, General Practitioner, Quinns Mindarie Super Clinic, Perth, WA; Emeritus Distinguished Professor, Curtin School of Population Health, Faculty of Health Sciences, Curtin University, Perth, WA

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RESEARCH LETTER

Delphi consensus: General practitioner role in follow-up of patients with a positive National Bowel Cancer Screening Program result

In this letter, we report on the subsequent findings from our previously published study on Delphi[1] round one key informant interviews with Western Australian (WA) general practitioners (GPs).[2] This study investigated experiences of GPs regarding follow-up of patients who returned positive immunochemical faecal occult blood tests (iFOBTs) through the Australian National Bowel Cancer Screening Program (NBCSP). Full study methodology is available in a detailed report.[3] This letter pertains to round two of the Delphi study, which was an online questionnaire aimed at establishing priorities and consensus of opinions from the Delphi round one interviews.

The 14 study participants who responded to the Delphi second round were WA-based GPs. Half (50%) were male, the majority were practising in metropolitan Perth and one was in the South-West region of WA. The questionnaire was open from December 2023 until January 2024. Results consolidated the findings of the first-round interviews in highlighting key issues in terms of involvement and inclusion in the bowel cancer screening process. Primarily, study

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results highlighted consistency across GP management of patients who return a positive screen. Agreement was reached on: patient contact attempted immediately or within one week, follow-up appointment with patient requested within 1–2 weeks, and referral of patient for colonoscopy. However, there was a perceived need for improving the National Cancer Screening Register (NCSR) and clinical software integration, as well as enabling GPs to promote alternative access to bowel screening kits, thereby improving the effectiveness of the NBCSP and reducing the burden on GPs. In fact, only one GP had used the alternative access option to order NBCSP kits. Half of the GPs noted that simpler kit diagrams and clearer test instructions would improve uptake. GPs were found to have a number of competing demands on their time and, thus, had limited opportunity to discuss the NBCSP during consultations. Ultimately, if GPs are to become more included and involved in encouraging patient participation and adherence to the NBCSP, it is essential to recognise the competing demands on GPs' time. Measures that acknowledge and address these time pressures will help facilitate more consistent GP engagement in the program.

Human Research Ethics Committee approval: The University of Notre Dame (ID 2023-005F).

Authors

Diane Arnold-Reed PhD, BSc (Hons), Associate Professor, School of Medicine, University of Notre Dame Australia, Fremantle, WA

Caroline Bulsara PhD, Grad Dip Educ Studies, BA (Hons), Research academic, Institute for Health Research, University of Notre Dame Australia, Fremantle, WA; Professor, School of Nursing and Midwifery, University of Notre Dame Australia, Fremantle, WA

Jane Gaspar BSc (Hons), Research Associate, Institute for Health Research, University of Notre Dame Australia, Fremantle, WA; Research Associate, School of Nursing and Midwifery, University of Notre Dame Australia, Fremantle, WA

Karen Taylor PhD, RN, BN, PGDipOnc, MNurs, GAICD, Cert IVTAA, Cert IVCouns, MACN, Adjunct Associate Professor, School of Nursing and Midwifery, University of Notre Dame Australia, Fremantle, WA

Anne Williams PhD, MSc, PGDipHS, BSc (Hons), Emerita Professor, College of Health and Education, School of Nursing, Murdoch University, Perth, WA

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Correspondence to:
caroline.bulsara@nd.edu.au

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correspondence **ajgp@racgp.org.au**

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