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Editor's choice

I have followed the RCGP's 'Put Patients First' campaign with interest and this article frustrated me further.¹ I would fully support more investment in general practice and see first-hand the difficulties we have with rising demand and more complex illness. However no-one has mentioned which services should be cut and disinvested in order to allow this percentage increase to occur? Any form of disinvestment in secondary care would impact on us as GPs, with longer waits for clinics, surgery, and investigations. We are already seeing the impact of disinvestment in mental health services, with patients potentially at risk. New funding needs to be invested in health care, the percentage that we as GPs get is broadly irrelevant. The current funding model for health care in the UK is fatally flawed and the sooner we realise that a universally free at point of service healthcare system is unsustainable, the better.

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REFERENCE

1. Baker M, Ware J, Morgan K. Time to put patients first by investing in general practice. *Br J Gen Pract* 2014; **65(623)**: 268–269.

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Asthma care in general practice

Mark Levy is to be congratulated for completing the review of asthma deaths.¹ However in the way that they take a narrow specialist perspective, the recommendations seem to have been written by specialist physicians rather than primary care generalists. Specialist asthma clinics were largely abandoned both because the profusion of different conditions that general practice now manages makes such arrangements impractical, but also because restricting the times when patients could have their asthma reviews made it less, not

more, likely that they would get any kind of review. As for the specialist training that he advises is the essential prerequisite for effective care, he must realise that, again, the large number of different conditions would place a burden on both nurses and doctors that will simply break the system. All that is required is familiarity with the latest research evidence and a willingness to try to apply them sensitively to the range of patients, with their range of asthma severity, taking into account those keen to manage themselves in a compliant way and those keen to deny the existence of their condition and anxious to reject all professional advice.

Every time that committed doctors investigate some particular area of practice they need to be reminded that the best primary care overall is provided by generalist doctors, and that any attempt to improve care for patients with particular conditions has to be integrated into general care and not bolted on as a vertical programme; and this is as true in the UK as it is in any developing country.

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REFERENCE

1. Levy M. Preventing asthma deaths: what can GPs do? *Br J Gen Pract* 2014; **64(624)**: 329–330.

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The importance of continuity of care

Dr Benett is right that access and continuity are interlinked and we agree that general practice needs investment in capacity.¹

However, it is disappointing to see a clinical director of a CCG writing that there is only 'equivocal evidence on the relationship between continuity and patient outcomes'. It is revealing that he uses Harold Shipman as evidence against continuity of care in a scientific journal.

With the doctor–patient relationship being as strong as it is, some adverse effects are inevitable. The 'heartsink' phenomenon is one² and there are a small number of studies suggesting delayed cancer diagnosis.³ Collusion is a problem in all clinical practice

and may be associated with continuity of care in general practice.

However, these adverse findings have all been countered, so that the same Rogers *et al* article³ also showed that increased trust in the doctor improved cancer detection, and trust in the doctor is itself associated with continuity of general practice care,⁴ while O'Connor *et al* showed that a regular provider was associated with significantly improved diabetes care.⁵

Directors of CCGs should know of the three really big gains in outcomes from continuity of care all of which matter to the whole NHS: increased patient satisfaction, better uptake of evidence-based preventive care, and, as research from Canada,⁶ Norway, the UK, and the US, consistently shows, fewer emergency admissions to hospital. Dr Benett's CCG is currently paying £1844 for each emergency hospital admission.

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REFERENCES

1. Benett IJ. Access, continuity, or both. *Br J Gen Pract* 2014; **64(625)**: 388–389.
2. O'Dowd TC. Five years of heartsink patients in general practice. *BMJ* 1988; **297(6647)**: 528.
3. Rogers S, Gildea C, Meechan D, Baker R. Access, continuity of care and consultation quality: which best predicts urgent cancer referrals from general practice? *J Public Health* 2014; DOI: 10.1093/pubmed/ftd127.
4. Mainous III AG, Baker R, Love MM, *et al*. Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom. *Fam Med* 2001; **33(1)**: 22–27.
5. O'Connor PJ, Desai J, Rish WA, *et al*. Is having a regular provider of diabetes care related to intensity of control? *J Fam Pract* 1998; **47**: 290–297.
6. Menec VH, Sirski M, Attawar D, Katz A. Does continuity of care with a family physician reduce hospitalizations among older adults? *J Health Serv Res Policy* 2006; **11(4)**: 196–201.

DOI: 10.3399/bjgp14X681301