

In addition to its close phylogenetic relationship, human metapneumovirus resembles RSV in that first infection does not seem to induce persistent immunity. Repeated infections with RSV are common throughout life. Indeed, 5–25% of all upper and lower respiratory infections in the elderly are due to RSV. Despite evidence of universal exposure by the age of 5 years, human metapneumovirus has also been documented to cause respiratory illness in young adults and in the elderly.⁶

The temporal pattern of human metapneumovirus infection is poorly defined. It certainly circulates during the winter, probably without the usual narrow monthly confines of RSV (November to January) and influenza (January to March). But we await descriptions of any seasonal peaks. Co-infection with other viruses may occur and there have been reports of significant worsening of RSV bronchiolitis if human metapneumovirus is present as well. Before the novel coronavirus causing severe acute respiratory syndrome (SARS) was discovered, human metapneumovirus

was mooted as a potential causative agent.

Human metapneumovirus is an important cause of respiratory infections in children. Despite the very recent identification of the virus, live attenuated vaccine development is already under way.⁷ Prevention of acquisition and transmission would significantly reduce the burden of childhood respiratory illness in the UK. Meanwhile, the development of near-patient tests will improve diagnostic accuracy of common viral infections in UK primary care and a full description of the clinical course of the infection will aid clinical management. Parents rightly want to know what is causing their child's symptoms and how long they are likely to last. Moreover, making a precise diagnosis of human metapneumovirus infection is sure to increase professional satisfaction among doctors working in primary care.

ANTHONY HARNDEN

University Lecturer in General Practice,
Department of Primary Health Care
University of Oxford

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ADDRESS FOR CORRESPONDENCE

Anthony Harnden

Department of Primary Health Care
University of Oxford
Old Road Campus, Headington
Oxford OX3 7LF

Email: anthony.harnden@dphpc.ox.ac.uk

The National Programme for Information Technology

The GP as gatekeeper — a bastion worth fighting for?

When Vannevar Bush described a process for making and following links between documents on microfiche in 1945,¹ did he have any idea that his suggestion would revolutionise the promulgation of information through society via what has become the internet? Chances are that he did not.

The invention of the internet has shown us how important a single change in the medium of information can be. The National Programme for Information Technology (NPfIT) has the potential to produce an equally significant impact in reforming the way that patient records are transcribed, transmitted and stored. More importantly, it has the potential to change forever the way in which health care is provided. We seem to be impervious to the implications of this change.

The rationale behind the development of NPfIT is a compelling one. The demands of the 21st century are often more than current healthcare systems can handle. Governments are beginning to realise that the utilisation of modern technologies is necessary in order to cope with these growing demands². As a result, NPfIT has captured the attention of international political, medical and public communities alike. It is human nature to be drawn towards what is new. In doing so, we often overlook the potential detractors of whatever it is that draws our attention.

Inevitably, the major concerns GPs have about the impact of NPfIT focus on choice of systems and potential disruption to current service. However, what doesn't seem to be recognised is that the vision of

the health service that underpins NPfIT is different to that which we know today. NPfIT is driven by a political agenda to change health care. One of the main thrusts of this for primary care is a 'supermarket' approach. A patient can select which service they want to use from a variety of general practices, walk-in centres, and privately provided and specialist services. Information systems are seen as the catalyst to this, as anyone can provide care given that they have access to the records. A logical conclusion from this is that the GP will no longer act as 'gatekeeper' (Anonymous, personal communication, 2004).

This vision is supported by a growing consensus that the traditional paternalistic culture of health care is gradually giving

way to a climate of shared decision making. The rising public awareness that GPs are neither infallible nor a protected species³ is supported by the change in rhetoric from 'doctor-patient relationship' to that of 'patient-professional'. This semantic change emphasises the precedence of the patient while subsuming the GP into the more general term of 'professional'.

The roles patients and GPs have traditionally held are changing, and we currently conceive medicine to be a commodity. This new-found freedom provides patients with a staggering range of choice. Today, the main message portrayed by this evolution in roles is that the patient has more power.⁴

Historically, patients have perceived visits to GPs' surgeries as more of an interrogation than as an act of cooperation. The GP asked a plethora of questions, ranging from patient history to immediate symptoms, and then recorded it on a medical chart. If a patient asked to see their own chart, it was unlikely that they were able to read what was written. For one thing, the paper chart was often illegible, and another, few electronic patient record systems allow the surgery to lock out one record from their entire database. The printed records of such electronic systems are out of context and consequently the chart is often no more comprehensible than its handwritten predecessor.

The advent of NPfIT has the potential to change this through its aim to create a single, comprehensive patient record, accessible by both patient and physician. The greater knowledge and access that this innovation will bring patients will change the way people approach their own care forever. The current doctrine of self-management is a throwback to Socrates' school of thought, which advocates the belief that 'each man is his own ruler'.⁵ Patients are beginning to become aware of a moral duty to make their own medical decisions.⁶ What frequently isn't highlighted, however, is their right to consult a professional who will make decisions for them when they choose to yield the responsibility.

NPfIT is likely to improve the availability of — and shared access to — patient records, but will it improve patient care? Experience suggests that most patients value the one

point of initial contact with someone they know and trust highly when experiencing significant health concerns. An important part of the GP's job has traditionally been to act as the patient's advocate in their experience of the NHS. It is therefore true that in many cases, what a patient wants is an escape from the tyranny of choice. In the medical field it does not take long for one to drown in a river of information, just as one can be parched in a desert of ignorance.⁵ This serves to warn us that the implementation of NPfIT may serve to give patients more control than they care to have.

Even though our society typically views choice positively, the tumultuous range of options we face on a daily basis may, in fact, be detrimental to our wellbeing. If patients can pick and mix their primary care, we believe there are significant problems that are not being considered. The experience in countries where primary care is provided by direct access to specialists shows that patients often do not go to the right specialist. How will they react if they have multiple choices for primary care? It will probably be argued that it works in other countries. In fact, these countries' policy makers are often jealous of the GP gatekeeper role in the UK.⁷ All who are ill, or think they are ill, are anxious. They do not necessarily have the experience, confidence or presence of mind to be able to select appropriate care. Choice may sound like a good thing, but when you are ill you need a friend who will make decisions both for and with you. GPs train for years to deal with these kinds of choices and are able to meet them somewhat objectively. Patients, meanwhile, are faced with an incredible emotional strain and may be unwilling to cope with the burdens that are brought on by patient autonomy. Perhaps a more gradual approach to the enfranchisement of patients would be more favourable for all parties concerned.

The patients and carers of tomorrow face a different world of health care than today's. As Oscar Wilde wrote, 'the future is inevitable.' As such, the progress of IT in health care is unstoppable, and the best we can do is to brace ourselves for the impact. While the NPfIT is lauded by many, we remain unconvinced that its impact on patients and professionals has really been

considered and addressed. Considering how well-advertised this new technology's benefits are, it may be wise to turn our attention to some of the other impacts that NPfIT is going to have on the field of health care; namely, how patients will be affected.

Therefore, perhaps it is best for GPs to stand fast in their role as patient advocates, and to work together with patients and other professionals to ensure that the good within the health service is not undone while excising the bad. We are certainly not advocating for the return of the GP as 'God', but rather that GPs retain their gatekeeper role as the health service moves forward. Jointly, patients and GPs can reap the benefits of these novel technologies as they find new ways of working together.

NICOLA SHAW

Research Scientist

GERGELY HEGEDUS

Research Assistant
Centre for Healthcare Innovation & Improvement, Vancouver

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ADDRESS FOR CORRESPONDENCE

Nicola T Shaw

Centre for Healthcare Innovation & Improvement
BC Research Institute for Children's & Women's Health
E414A-4480 Oak Street
Vancouver, British Columbia
CANADA V6H 3V4
E-mail: nshaw@cw.bc.ca