1448 Dumbarton Road
Scotstoun
Glasgow G14 9DW

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1. Deehan A, Taylor C, Strang J. The general practitioner, the drug misuser, and the alcohol misuser: major differences in general practitioner activity, therapeutic commitment, and 'shared care' proposals. *Br J Gen Pract* 1997; **47:** 705-709.

Sir,

We were disappointed to see how unwilling the group of GPs surveyed by Deehan *et al* (November *Journal*)[1] were in their responses to managing drug misusers. We believe, however, that with the right intervention GPs can change their behaviour towards drug misusers if not their attitudes.

We, in South London, have, for the past three years, run a consultancy and liaison service for the GPs in Lambeth, Southwark and Lewisham Health Authority (LSLHA) offering what we believe to be a comprehensive model of shared care, which includes face-to-face contact, easily accessible telephone advice, and training for primary care health staff. Within the past year, the Consultancy Liaison Addiction Service team (three nurses and one part-time GP consultant) has worked with 29 surgeries, providing help in managing their alcohol and drug-dependent patients. In this group are GPs who, prior to our service, were not managing dependent patients at all, quoting lack of resources and back up from colleagues as reasons for non-involvement.

Like Deehan *et al,* though unlike Gruer *et al* in Glasgow,[2] we would accept that money is not the main incentive to change. Within LSLHA additional funds for GPs caring for opiate users within a shared care model were made available. The numbers of drug misusers treated by GPs in LSL has not increased. Perhaps success is due to shared care, and additional resources should be put into expanding this way of working. Now is the time for GPs in all areas to get off the fence and positively participate in the care of this needy group of patients.

CLARE GERADA
CLIVE BARRETT
JO BETTERTON
JAMES TIGHE

Consultancy Liaison Addiction Service
Hurley Clinic
Ebenezer House
Kennington Lane
London SE11 4HJ

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Nurse practitioners

Sir,

The editorial by Koperski *et al* (November *Journal*)[1] on the subject of nurse practitioners (NPs) seems to suggest that there is an inevitable progression towards NPs taking an increasing role in general practice. I do not agree that this is necessarily a good thing.

The principle of 'practice makes perfect' has already led to the emergence of many different roles and specialties within the health care professions. NPs in general practice represent another new nursing specialty. The impetus behind their emergence is the continuing identification of new areas where it is those who perform tasks most often whose patients have the best results; often it doesn't seem to matter whether a doctor or a nurse performs these tasks.

General practitioners traditionally feel that the strength of their position hinges on their being the last true generalists in medicine. In defence of this they look to develop others' roles, to delegate, when changes are needed. This is a dangerous tactic.

If NPs are more successful than doctors in certain roles,[2] it is not because they are nurses per se, but because they are using skills that doctors are not. Perhaps GPs should consider learning some of these skills. And if the skills are simply those derived from frequent practise of a task, that is an argument for sub-specialization by GPs.

The demonstration of the worth of NPs seems to be mainly by those who are already ideologically committed to the concept. In fact, there are other solutions to the problems NPs apparently help to solve. However, those solutions will mostly involve GPs having to become more flexible about their own role.

There is a continuum from absolute specialist to absolute generalist. Perhaps GPs should try sliding a little further along from their end of it.

SAUL MILLER

7 Newlands Farm Cottages
Belford
Northumberland NE70 7DS

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Management of hypertension

Sir,

From Oxfordshire it emerges that factors other than recommendations in hypertension guidelines appear to be responsible for the variation in hypertension control between practices;[1] and from The Netherlands comes evidence that one of these factors appears to be organizational: an important finding is that only 5% of practices have protocols.[2]

In our practice, we decided that, with our high consultation rate, high non-attendance rate, and already large administrative burden, a recall system[2] would not be appropriate. We therefore devised a framework for opportunistic risk-based blood pressure monitoring, adapted from local[3] and national[4] guidelines and simple enough to be held on half a sheet of A4. For patients aged 30-79 (and older if not housebound), feeling generally well and neither pregnant nor terminally ill at the time of their consultation, the nurse (or doctor) will follow the flowchart (Figure 1).

The simplicity of this framework may make it attractive for other practices and help overcome organizational barriers to vascular disease prevention.

WILFRID TREASURE

Muirhouse Medical Group
1 Muirhouse Avenue
Edinburgh EH4 4PL

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