

Senior managers' views on implementing clinical governance <i>T Greenhalgh and F Macfarlane</i>	940
Proposed new GP contract <i>A Williams</i>	940
Managing alleged performance problems <i>D Blaney</i>	941
Drug rationing in the UK <i>P Wood</i>	941
Medical services in nursing homes <i>A J Dow</i>	942

Viral hepatitis C testing <i>V Thurlow and H Smith</i>	942
GPs with special interests <i>A Lamb</i>	943
	<i>T F Poyner</i> 943
PDP put-down <i>P Johnson</i>	943
Management of anxiety in primary care <i>S P Dearman and V Nathoo</i>	943
Symptoms of vertigo in general practice	

J Sharvill 944

All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to journal@rcgp.org.uk (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Senior managers' views on implementing clinical governance

Many of us feel intuitively and anecdotally that culture is at the heart of resistance to change in primary care organisations (PCOs). Marshall *et al* are to be congratulated on attempting to identify 'cultural barriers' to achieving clinical governance and possible methods of overcoming them.¹

But as the authors themselves acknowledge, their study has important limitations as a study of organisational culture.^{2,3} They asked 50 senior NHS managers a series of open-ended questions pertaining to the implementation of clinical governance in their PCOs. They analysed the transcripts for 'explicit and implicit references to culture, shared values, norms, and beliefs', as well as to 'cultural diversity, cultural change, and desired cultural destinations'. But despite the fact that three-quarters of informants used the word 'culture' and most talked about beliefs, values, and ways of working, a rich picture of prevailing culture in the relevant PCOs and the extent to which the culture is actually changing or not, does not emerge in the paper. Instead, the results section mainly comprises an extremely useful list of perceived successes in, and barriers to, implementing clinical governance in the eyes of senior managers. This is hardly surprising, since that was precisely what the questionnaire was asking!

Marshall *et al* are aware that culture is a difficult concept to study empirically and they perceptively warn that the informants 'may have regurgitated policy statements [on the need for 'cultural change' in primary care] rather than reflecting the real difficulties of service management'. They now plan to link the findings of this study with additional data to build a more robust picture

of the prevailing cultural terrain. However, we hope that they will also make direct use of the valuable data they have already collected on barriers to change in PCOs and suggestions for overcoming them. A re-analysis of their raw data might, for example, identify important specific training or resource needs for different staff groups.

While perceptions about culture may indeed be discerned through a series of one-off interviews, a picture of the culture of an organisation can only be built by agreeing — arbitrarily if necessary — a set of domains that count as the organisation's culture and then systematically measuring these using qualitative and quantitative methods. A number of validated survey instruments are available and widely used.⁴ To measure cultural change, a longitudinal study must be done by collecting data on at least two time points.

The linked editorial by Helman⁵ appears curiously detached from the aims and key message of Marshall *et al*'s paper.

TRISHA GREENHALGH

Professor of Primary Health Care,
University College London, 4th Floor,
Holborn Union Building, Highgate Hill,
London N19 5LW. E-mail: p.greenhalgh@pcps.ucl.ac.uk

FRASER MACFARLANE

Lecturer in Health Service
Management, University of Surrey

References

1. Marshall M, Sheaff R, Rogers A, *et al*. A qualitative study of the cultural changes in primary care organisations needed to implement clinical governance. *Br J Gen Pract* 2002; **52**: 641-645.
2. Handy C. *Understanding organisations*. London: Penguin, 1993.
3. Schein E. *Organizational culture and leadership*. New York: Jossey-Bass, 1992.
4. Furnham A. *The psychology of behaviour*

at work. Hove: Psychology Press, 2001.

5. Helman C. The culture of general practice. *Br J Gen Pract* 2002; **52**: 619-620.

Proposed new GP contract

Three major aspects of the proposed contract concern the following points:

1. At his Portsmouth presentation, Lawrence Buckman made it clear that the concept of holistic, longitudinal, family care provided by a named doctor was dead. ('The Government is clear that patients want immediate access to a healthcare professional, rather than continuing care with their own doctor'). Not only does this seem to be at odds with the preference stated by the patients and friends I know, it also seems to run counter to a large corpus of teaching of the Royal College of General Practitioners. It also runs counter to the statement made by Dr Chisholm in his letter of 9 April 2001, when he asserted: 'When they are ill, patients want to be able to see their doctors, not to find that their GP is having to undertake administrative tasks in order to satisfy Government.'
2. About a million consultations take place every day in the United Kingdom. Perhaps GPs could consult patients about the value they place on access to their own GP and suggest that the Prime Minister, Mr Tony Blair, be made aware of their views.
3. The contract fails to describe how workload is to be capped. All the existing infinite availability to those who are unwell is to be preserved (and patients' satisfaction with this service is to be measured and will become a determining factor in

GPs' pay) and, in addition, GPs will be set on a biennial upward ratchet of contracted tasks.

4. If resourcing of 'additional services' is as certain as the framework asserts, then it is better that the default position of these services is that they are voluntary. Practices will leap to carry them out if the resources truly are there.
5. Acceptance of the framework is bad news in practical terms. Credibility will be lost if GPs sign up to a framework with fundamental flaws; to reject it subsequently at the pricing stage will be seen only as quibbling about money. Matters of principle should be voted on at the first, not the second ballot. The negotiating team first needs to conduct a debate about the value of the role of 'essential medical services'. This is a debate that the public will understand, without the subtleties and complexities of the available extra payments.
6. Such a debate will allow a proper price for the basic job and extra resources will be just that. To negotiate them all together, at the same time, will leave GPs complaining about the low levels attributed to basic services to which we may be first allocated, leaving the Government negotiators able to quote the highest potential earnings.

I urge you to reconsider the negotiators' current recommendations, and I welcome your proposals, in particular regarding the mobilisation of the patients' views about the proposed loss of general practice that they value.

ANDREW WILLIAMS

The Lake Road Practice, Nutfield Place, Portsmouth, Hampshire PO1 4JT.

Managing alleged performance problems

In their editorial, Wilson and Haslam ask the question 'Managing alleged performance problems — are we ready?'.¹ The answer is: yes.

In July 2001, the Scottish Executive published *Prevention better than cure: ensuring safer patients and better doctors*. This was the outcome of a short-life working group on identifying and preventing underperformance among GPs. The document set the framework for both identifying and supporting underperformance in Scotland. The critical components of this system were the emphasis on local remediation where possible and, when this proves impractical, referral to an independent national assessment process.

In Scotland, any GP whose performance is a cause for concern is referred into a local support network under the guidance of the Medical Director of the local Primary Care Trust. If the local support network identifies that the problems are sufficiently serious, it can refer the doctor to the external assessment network, which has been set up under the auspices of NHS Education for Scotland (NES). The external assessment network comprises 12 trained assessors. The assessors work with an assessment format similar to that of the GMC performance assessment. Their purpose is to produce an educational diagnosis and prescription for the doctor and the Trust. There is, in addition, a national remediation network, comprising associate advisers with specialist interest and skills in re-training and educational appraisal, who work closely with the Trust on receipt of the educational prescription to ensure its implementation at the local level.

The separation of the assessment and remediation arms of the process has been critical to the development and acceptance of the system by the profession. The Primary Care Trust retains responsibility for the doctor's overall performance and NHS Education for Scotland has responsibility for the educational assessment and educational support.

The Medical Director of the Trust commissions the external assessment and funds it, and in addition supports the doctor while they re-train. NES funds the training of the external assessors and supports the education and remediation through the associated adviser network, and by offering GP trainers who take doctors requiring re-training up to three times the normal

training grant.

In Scotland we are moving towards having a national system for the identification, assessment, and re-training of all doctors, irrespective of their specialty. The aim is to have one point of referral for all doctors, be they in training or in service posts. The assessment tools are largely generic and, where there is a specialty requirement, appropriate assessors will be involved.

Our hope is that the introduction of this system will lead to increased identification and remediation of performance issues at a local level. This will prevent a number of doctors being referred to the General Medical Council and will ensure that public confidence in the profession in Scotland is maintained.

DAVID BLANEY

Director of Postgraduate GP Education, NHS Education for Scotland (South East Region), 11 Hill Square, Edinburgh EH8 9DR

Drug rationing in the UK

Dr Kernick is to be congratulated on his essay about rationing, which highlights several uncomfortable issues.¹ As a physician working in the pharmaceutical industry I am accustomed to meeting suspicion when the motives of the industry are discussed. However, while it is undeniable that making a profit is essential, it is equally evident that this is achieved through the development of new medicines that allow effective treatment of disease. The introduction of disease-modifying agents for multiple sclerosis (MS) is an example of this. However, few people with MS in the United Kingdom have had access to this therapy (6% in the UK, 34% in Germany, 70% in the United States). The political machinations discussed by Dr Kernick must not obscure the obvious clinical need of people with MS in the UK.

Some of the information that Dr Kernick presents, however, is incorrect. Beta-interferons are not the only licensed treatment for multiple sclerosis. Glatiramer acetate was licensed for us in the UK in August 2000. A reduction in the relapse rate of 32%

was shown in a placebo-controlled study of up to 35 months. When continued on an open basis, efficacy was sustained for up to six years. Guidelines for treatment, produced by the Association of British Neurologists, accept the efficacy of glatiramer acetate.

Dr Kernick complains that the use of MS disease-modifying agents will adversely influence the provision of other neurology services. However, the only suggestion being made is that treatment should be offered to those patients who fulfil the criteria established by the Association of British Neurologists. To assist in this, resources are being increased with funding from the NHS and from the manufacturers, thereby addressing Dr Kernick's contention that the problem is being shifted elsewhere. Teva Pharmaceuticals is standing firmly behind the data on glatiramer acetate and, as a provider of funding, really is putting its money where its mouth is. Why should this be met with suspicion? People with MS in the UK have every right to expect effective treatment, which we as doctors know is available.

PHILIP WOOD

Medical Director, Teva
Pharmaceuticals Ltd, Barclays House,
1 Gatehouse Way, Aylesbury,
Buckinghamshire HP19 8DB.

Reference

1. Kernick D. Beta-interferon, NICE, and rationing. *Br J Gen Pract* 2002; **52**: 784-785

Medical services in nursing homes

I was surprised to find, in the July 2002 issue of the *BJGP*, how much personal opinion can pervade an otherwise useful research report: Glendinning *et al* concluded that the current system, whereby GPs take a lead in providing care in certain nursing homes, is inequitable and against patient choice. They seem to neglect two very important choices.

First, there is the choice of the GP with whom the individual is registered, at their current address, wishing to

remove them because they are now relocated to a new address and many of us, as caring GPs, tend to keep patients we know (or their relatives) on our panel, despite them moving to nursing homes that would otherwise be outwith our patch. Although this is, to an extent, undoubtedly altruistic, is it really an efficient use of NHS resources for us as GPs to pass each other in opposite directions, arriving at homes with six of us in attendance to see six different patients?

The greatest choice of all is that of the patient and their relatives to elect to have their medical care in a home that has an attached doctor who will take them on, without quibble, and has a planned predefined meeting on a regular date for reviewing medication, meeting relatives, and familiarising themselves with the patients. This level of service is not logistically feasible if a doctor only has a couple of patients in a nursing home and yet it is certainly the choice I would exercise on behalf of my relatives. It is undoubtedly inequitable that different homes provide different levels of care, staff, and services; similarly so do different practices and — perish the thought — different doctors. Maybe the cry of 'inequitable' is one that has had its day?

ALAN J DOW

Cottage Lane Surgery, 47 Cottage
Lane, Gamesly, Glossop, Derbyshire
SK13 6EQ.

Viral hepatitis C testing

The rising number of patients infected with hepatitis C virus (HCV) has led to a debate regarding testing. Regional variation exists in the availability of the screening test, viral hepatitis C antibody (HCV Ab). Inner-city laboratories, such as those in London and Glasgow, expect to provide the test routinely; however, some provincial laboratories do not. The cost of the serology is a disincentive to providing the assay if HCV is thought to be unlikely and request numbers are low. GPs may well consider the following questions: are all patients who should be tested being offered the test? If you

refer a patient for a blood test, is a result received from the pathology laboratory?

It is now recognised that GPs are seeing increasing numbers of asymptomatic patients with raised liver enzymes. Persistent unexplained elevation of transaminases, with or without lifestyle risk factors (e.g. intravenous drug use), is an indication to exclude chronic viral hepatitis B/C and would be recommended.¹

Personal experience when adding this recommendation to biochemistry laboratory reports was an increase in requests for HCV serology. Problems arose in one provincial district general hospital that did not provide HCV Ab testing. There were cost implications and the microbiologists demanded that the recommendation to exclude viral hepatitis should cease. The HCV test requests received were screened and not processed unless certain criteria were met.

Because of this, a small survey, supported by a local research grant and approved by the local ethics committee was carried out by the Biochemistry Department of this district general hospital. Serum samples collected between August 2000 and January 2001 from 120 GP patients, who had had persistently elevated liver enzymes (alanine aminotransferase and/or γ -glutamyl transpeptidase) unexplained by medications, alcohol, diabetes, known viral infections, etc, on at least two occasions (information was sometimes withheld), were tested for HCV Ab. The anonymised samples were drawn from a mainly Caucasian and relatively affluent population, for whom risk of HCV might be considered low and similar to that of blood donors (0.044%).² HCV serology was carried out in the Liver Unit at King's College Hospital in London, using a Microparticle Enzyme Immunoassay System (Abbott Diagnostics, Maidenhead, UK).

All 120 samples were negative for hepatitis B, but six tested reactive for HCV Ab (5% versus 0.044% in blood donors). This represents a 100-fold increase above background and supports a policy of offering HCV Ab testing to patients with persistently raised liver enzymes. However, who should decide which patients are offered test-

ing — GPs or pathologists?

VANESSA THURLOW

Principal Biochemist, Maudsley
Hospital, London SE5 8AZ

HEATHER SMITH

Consultant Clinical Scientist, Institute
of Liver Studies, King's College
Hospital, London SE5 9RS.

References

1. Albrecht JH, Jenson DM, Peine CJ, Schiff ER. Transfusions to tattoos: the dangers of hepatitis C. *Patient Care* 1996; **30(12)**: 112-139.
2. Communicable Disease Report: Surveillance of viral infection in donated blood: England and Wales 1998. *CDR Weekly* 1999; **9(38)**: 340.

GPs with special interests

Working as both a general practitioner and a hospital practitioner in the NHS, I was delighted to see and read the various articles on GPs with special interests in the October edition of the *BJGP*.¹⁻³ It is time there was more open debate and discussion on the role of general practitioners working outside the confines of their own practices.

GPs have done work in secondary care since time immemorial. However, this work has been done more out of altruism than financial gain. Clinical assistant and hospital practitioner posts have not been remunerated at such a level as to provide locum cover within their own practices. This has led to difficulties and conflicts for some of those wanting to work partly in secondary care, yet be 'fair' with their partners in practices in primary care.

What is coming to the fore in intermediate care is the need for proper financial reward for the contribution made by the GP in improving the care and services to patients in the NHS. What is needed is for all GPs working in the NHS to feel valued when working both within and outside their own practices. GPs should be able to work without feeling guilty that they may be expecting their partners or practices to pick up the financial loss, when patients are benefiting from their increased skills and knowledge.

THOMAS F POYNER

General Practitioner and Hospital
Practitioner in Dermatology, Stockton
on Tees.

References

1. Jewell D. October Focus. *Br J Gen Pract* 2002; **52**: 793.
2. Gerada C, Wright N, Keen J. The general practitioner with a special interest: new opportunities or the end of the general practitioner? *Br J Gen Pract* 2002; **52**: 796-7.
3. Jones R, Bartholomew J. General practitioners with special clinical interests: a cross sectional survey. *Br J Gen Pract* 2002; **52**: 833-834.

In their October editorial on GPs with a special interest (GPwSIs),¹ Gerada *et al* conclude that 'New roles for GPs will help to finally put to rest decades of prejudice against general practice'.

If generalists can only improve their standing by resorting to increasing specialisation, what does this say about the value of generalism itself? This rather risks the development of two tiers of GPs, with those who specialise being held (wrongly) in higher esteem than 'mere' generalists.

We need to continue to argue the case for generalism *per se*; crowing about the esteem that specialisation will bring is self-evidently an illogical way to go about this!

I am not opposed to the concept of GPwSIs, but let us not pretend that they are 'the future' of *general* practice, or that they will do anything to improve the reputation of the true generalist.

ANTHONY LAMB

GP Principal, Browning Street Surgery,
Stafford ST16 3AT. E-mail
ablamb@doctors.org.uk

References

1. Gerada C, Wright N, Keen J. The general practitioner with a special interest: new opportunities or the end of the generalist practitioner? *Br J Gen Pract* 2002; **52(483)**: 796-798.

PDP put-down

In his dynamite demolition of personal development plans,¹ Dr David Tovey draws on a 'funny, scathing' article by

Dr Tony Copperfield² but then takes a rather mean-spirited, parenthetical swipe at the publication which published it, writing: 'Doctor magazine (no, I don't read it either, it was pointed out to me).' For the record, not only does *Doctor* have the best GP columnist in the business (and much more besides), but the latest independent survey of readership of medical publications by GPs in the UK³ gave *Doctor* an average readership of 62% and the *BJGP* one of 23%.

PHIL JOHNSON

Editor, *Doctor*, Reed Business
Publishing, Quadrant House, The
Quadrant, Sutton SM2 5AS

References

1. Tovey D. Professional Development Plans. *Br J Gen Pract* 2002; **52**: 865.
2. Copperfield T. Can't we just knock PDPs on the head? *Doctor* 4 July 2002: 21.
3. Joint Industry Committee of Medical Advertisers for Readership. *National Medical Readership Survey*. JICMARS: April 2001-March 2002, 1-2.

Editor's note

Why is Phil Johnson bothered? Much worse comments are regularly levelled at the *BJGP*.

Management of anxiety in primary care

Anxiety disorders may occur in up to 33% of patient populations.¹ The financial burden of this is unknown; however, the clinically anxious constitute more than one in five of high service-utilising patients.²

The RCGP has supported the use of guidelines and quality care standards.³ Evidence from the United States suggests that guidelines improve patient outcomes and primary care practice.⁴ Little research has considered anxiety disorders; most literature concerns generalised anxiety disorder (GAD) and epidemiological studies are lacking. It is perhaps for this reason and the initial reservation in accepting GAD that very little management literature exists.

The general consensus is that benzodiazepines should be used to treat acute anxiety, Buspirone for persistent

anxiety, and selective serotonin reuptake inhibitor (SSRI) antidepressants for associated panic.⁵ Recommendations for referral to secondary care are less clear.

How anxiety is being managed in primary care or the proportion of patients referred to secondary services is unknown — GP referral rates vary by up to twenty-fivefold.⁶ Understanding these issues would provide a basis for development of future guidelines and aid determination of budgets and resource allocation.

We recently identified all patients clinically diagnosed with anxiety disorder in the Five Oaks Family Practice, Manchester. All patients receiving *British National Formulary* listed drugs for the treatment of anxiety were also identified; lists were cross-referenced revealing individuals not at first discovered. Notes of these patients were read to confirm diagnosis. Referral letters and replies were read to establish secondary care utilisation.

The patient population numbered 7348. Of these, 51.6% (3795) were male and 48.4% (3553) were female. Sixteen per cent (1165) of patients were diagnosed with anxiety disorders and their mean age was 42.4 years (range = 16 to 92 years). Ninety-two per cent (1070) were managed solely in primary care, with four (0.3%) seeing a counsellor. Ninety-eight patients (8.4%) received anxiolytic medication; of these 68 (69.4%) received Diazepam, 20 (20.4%) received Lorazepam, five (5.1%) received Paroxetine, three (3.1%) received Oxazepam, and two (2.0%) received Fluoxetine.

Ninety-five patients (8.2%) were in secondary care. Multidisciplinary services were utilised as follows: 65 (68.4%) patients were under the care of a psychiatrist; 36 (37.9%) a community psychiatric nurse; 34 (35.8%) a clinical psychologist (four for psychotherapy and 30 for cognitive behavioural therapy) and seven (7.4%) a social worker.

In the absence of explicit evidence-based guidelines, we cannot comment on whether these findings represent good practice. More research in anxiety is required with regard to its aetiology generally and in primary care. Simple studies such as this, if replicat-

ed nationally (and internationally), would create a wealth of knowledge from which we might produce evidence-based protocols, and hence better informed pragmatic care.

SAMUEL P DEARMAN

Final-year medical student, University Of Manchester.

VIJAY NATHOO

General practitioner, Five Oaks Family Practice, Beswick, Manchester

References

1. Fifer SK, Mathias SD, Patrick DL, *et al.* Untreated anxiety among adult primary care patients in a Health Maintenance Organisation. *Arch Gen Psychiatry* 1994; **51**: 740-750.
2. Katon W, Van Korff M, Lin E, *et al.* Distressed high utilisers of medical care: DSM-III-R diagnoses and treatment needs. *Gen Hosp Psychiatry* 1990; **12**: 355-362.
3. Royal College Of General Practitioners. *The Development And Implementation Of Clinical Guidelines*. [Report from General Practice Number 26.] London: RCGP, 1995.
4. Schulberg HC, Block MR, Madonia MJ, *et al.* Treating major depression in primary care practice: eight-month clinical outcomes. *Arch Gen Psychiatry* 1996; **53**: 913-919.
5. Hales RE, Hilty DA, Wise MG. A treatment algorithm for the management of anxiety in primary care practice. *J Clin Psychiatry* 1997; **58**(suppl 3): 76-80.
6. Wilkin D, Smith A. Variation in general practitioners' referrals to consultants. *J R Coll Gen Pract* 1985; **35**: 15-18.

Symptoms of vertigo in general practice

I found the article in the October issue by Hanley and O'Dowd¹ reassuring, in that what we do for patients with vertigo is essentially clinical medicine. I remain a little worried, however, that we are reassuring patients that they have viral/epidemic neuronitis with no hard evidence. My limited experience in patients who have been investigated with magnetic resonance imaging scans is that they have had vascular events with no other clinical signs. The average age in this study was 52 years. Might I ask, if anybody is to repeat a study like this, that they try to get co-operation from the hospital sector so that diagnosis can be confirmed by the absence of other pathology?

JOHN SHARVILL

General practitioner, Deal, Kent.

References

1. Hanley K, O'Dowd T. Symptoms of vertigo in general practice: a prospective study of diagnosis. *Br J Gen Pract* 2002; **52**: 809-812.

Correction

In the July 2001 issue of the *BJGP*, Tables 2 and 3 in the paper by Stoddart *et al* (*Br J Gen Pract* 2001; **51**: 548-554) contained incorrectly transposed 'yes' and 'no' responses. We apologise to the authors and the readers for this error and for any confusion it may have caused.