

Editor's choice

Assisted dying

Professor Finlay is absolutely right that GPs' opinions are vitally important in the assisted dying debate, and that it is important for the College to have a view on this issue.¹ Physician-assisted suicide would involve GPs in assessing requests for assisted suicide and would also require GPs to prescribe lethal doses of medication. It would also be highly stressful for GPs, as seen in the Netherlands. It is vital that GPs' views are expressed and taken into account by legislators. It is also vital that any change in the College's position is only made after a ballot of members. This is not a difficult thing to do, and is vital to ensure transparency and openness. Professor Finlay's Viewpoint piece is a timely and welcome contribution to the physician-assisted suicide debate.

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Sustainability in primary care

The very mention of 'sustainability' is usually enough to send me screaming from the room, and so I was minded to skip over Tim Ballard's editorial on the subject.¹ I'm glad I chose instead to read what he had to say, as I would otherwise have missed an unusually thoughtful and thought-provoking article.

He points to the role of the GP in providing 'high quality generalist personalised care' and argues persuasively that such an approach is resource efficient. He extends this argument to consider the potential impact of commissioning and the opportunity this provides for avoiding unnecessary duplication of services. However, my experiences to date suggest that the precedents are not

encouraging, and I have observed that most commissioning decisions made in the name of efficiency achieve anything but (unless this is the same type of efficiency that persuades manufacturers to outsource their labour abroad).

The real sustainability challenge for primary care is whether we have the courage to resist the juggernaut that is the healthcare industry and regard health care as a precious resource rather than a consumable. I suggest that every unnecessary prescription, every unnecessary screening service, and every unnecessary referral we provide for our overwhelmingly well patients is a misuse of this resource. I also agree with Ballard that we should resist taking undue responsibility for the consequences of excess consumption; much that passes for health promotion is indeed shutting the stable door after the horse has bolted, as he well describes. Again, precedent suggests that we have a way to go in this regard; how else to explain our unquestioning adoption of much of the QOF, over 50s health checks, and other ill-conceived health promotion initiatives?

Anyway, I had better stop writing now as I can see my surgery car park is filling up with the impressively fuel-efficient cars of those arriving for their health checks. While our practice nurse is seeing them, I should get on with signing the rainforest's worth of repeat prescriptions. Funny, but the pile seems to be getting bigger all the time ...

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Carbon footprint of patient journeys

May I add one further aspect to the discussion relating to patients travelling to and from surgeries and its environmental impact^{1,2} that I have yet to hear included in any public

debate — and that is the obvious conflict with the 'choice' agenda. We, too, are a practice in a deprived inner-city area with high rates of chronic disease, and yet a significant number of our patients still drive 3, 4, or 5 miles through town to visit the practice. It is not uncommon for patients to ring saying they will be late as they are 'stuck in traffic' or be stressed if the doctor is running late and they have only paid for 30 minutes on the meter. Ironically, they will have driven past or close by to at least some seven or eight surgeries on their way in.

We will all be familiar with the disgruntled patient who does not see why they have to change doctors even if they have moved a considerable distance away. Yet government initiatives have been to promote keeping such patients on the list.³ The current patient choice agenda seems to pay little heed to such genuine wider concerns as this study demonstrates; and ignoring them does not make them go away.

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3. Department of Health. *Your choice of GP practice: a consultation on how to enable to register with the GP practice of their choice*. London, DoH, 2010.

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Managing dyspepsia in primary care

It was interesting to note that both authors of the article *Initial management of dyspepsia in primary care* were secondary care physicians.¹ In their otherwise practical approach to managing this common problem, no mention was made of upper gastrointestinal symptoms occasionally being the only early warning of possible ovarian malignancy. Many GPs would now consider arranging a CA125 blood test.