Letters

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TIME to take antihypertensives

I too was interested in the extraordinary outcome of this single-centre trial,[1,2] and it has unquestionably influenced my practice since its publication. Thankfully, and ethics notwithstanding, this same question HAS been studied again in a UK population.[2]

For better or worse this large trial did not support the outcomes of the earlier study, so it is best to advise patients to take their tablets at a time most convenient for them.

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Medical musings: GPs should be the orchestra

I thank Dr Mummery for writing this article[1] and I hope it is taken on board by those who are driving the changes in primary care. May I though reflect that one unspoken concern is that nobody polices primary care as we are independent contractors, and whether a practice provides extra services (for example, ear syringing) or works more sessions for its income is not checked.

In the past the family practitioner committee was feared as it had power and sanctions. With the recent bad publicity about access and the numbers of face-to-face consultations, Dr Mummery's comments about being on primary care network (PCN) committees versus seeing patients and offering continuity are so pertinent.

There is no dispute that demand greatly exceeds capacity in the whole of the NHS, but we have just had a local medical committee (LMC) vote to reduce the working day to 9 to 5 without any loss of income.

Could GP funding be rearranged so that instead of paying for pointless and often dangerous targets (HBa1 in older patients as an example), they paid a huge dividend for continuity and access?

GP partnerships have in the main always responded well to funding-related work.

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What did we learn from the era of big data?

I would like to thank Professor de Lusignan *et al* for their extremely constructive and up-to-date comments about 'Data saves lives',[1] which may help healthcare professionals in the broader health community to achieve data-based, goal-oriented diagnostic and treatment strategies. However, as a young GP who experienced the entirety of the COVID-19 pandemic, I can't help but question whether the data we see with our naked eyes are credible.

First, routine health data may influence treatment strategies and vaccination against COVID-19, but the data are highly biased due to differences in policies and populations (including gender, age composition, and literacy) across regions. Therefore, conclusions and strategies from extensive health data may not apply to all regions.

Second, the so-called Trusted Research Environments (TREs) proposal may exist only in the ideal. We cannot grant people's wishes, either in terms of transparency or openness of work, because there is social stability, an economic bias, and an orientation to decision making. The criticism will probably always be there.

Third, innovation and centralisation are, in fact, in conflict with each other. The expertise of so-called expert teams is probably, in most cases, generated in centralisation. Thus, the federated TRE model may still end up being swallowed up by centralisation.

As de Lusignan *et al* said, *'Top-down changes can cause unintentional disruptions and render a complex ecosystem dysfunctional.'* However, in the age of big data, if data frameworks, data quality, and trustworthy research environments are not established in a practical, truthful, and standard way, then the seemingly transparent data would be the start of the following health problem chaos of this era. As a GP in a third-world country, I look forward to applying a thriving but sensitive health data ecosystem to assist in primary care systems' diagnosis and treatment strategies in the post-COVID-19 era.

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