annual review of patients with hypertension, and the advent of the GPs' new contract provides opportunities for this to be done.

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Hepatitis B vaccination

We were pleased to hear of another primary health care team actively vaccinating intravenous drug users against hepatitis B.[1] We have also found hepatitis B vaccination in primary care to be feasible and effective, but we have modified our practice through a number of audit cycles. We provide an outreach service to homeless patients in Leicester and we began by offering bloodborne virus screening to all intravenous drug users before offering vaccination on the traditional 0, 1- and 6-month schedule. We audited the outcomes for all drug users starting a methadone treatment programme over a 6-month period. The first audit of 23 patients treated in the 6 months to September 2000 found that only 48% were screened; nearly all of our patients are long-term intravenous users and gaining venous access is often difficult. This delayed vaccination so that only 65% received it. As a result we decided to offer opportunistic vaccination if screening was not achieved after 8 weeks, a computer prompt was set up at the start of each treatment programme to remind the clinician at each consultation. Our second audit of 31 patients starting treatment in the 6 months to September 2001 found that 97% had received the hepatitis B vaccine during the audit period but only half had completed three doses. Bloodborne virus screening had been performed for 65% of patients with another 32% screened elsewhere (e.g. criminal justice system or genitourinary medicine clinic.) Forty-five per cent of our intravenous drug-using patients were positive for hepatitis C. As a result of this audit we decided on three modifications to our practice; we would use combination hepatitis A and B vaccine on the grounds that nearly half of our patients were hepatitis C-positive, even if they did not yet know it, and so would warrant hepatitis A protection, and we decided to use the accelerated schedule with doses given at 0, 7 days, 21 days and 12 months, starting the schedule opportunistically at the first contact without waiting for blood screening. Our argument was that giving the vaccination to patients who had already had hepatitis A or B disease would not be harmful. Instead the vaccine would only be ineffective, but delay for unsuccessful blood screening could leave patients exposed to risk. Our third audit of 22 patients starting treatment in the 6 months to September 2002 found that 20 (91%) received three doses of vaccine with two patients declining consent to vaccination. However, we had increased vaccination uptake at the expense of blood screening; only 68% of this group of patients had had bloodborne virus screening in the previous 2 years. The most recent audit of 31 patients treated in the 6 months to September 2003 showed that we had maintained a high level of vaccination with 27 (87%) having 3 or more doses of hepatitis B vaccine and 26 (84%) fully vaccinated against hepatitis A. During this period we had also increased the rate of bloodborne virus screening to 81%.

A key component of achieving such high vaccination rates for a chaotic and hard to reach group was the provision of a well stocked vaccine fridge in every consulting room, so that the consulting doctor or nurse could offer immediate vaccination when the patient presented rather than waiting for a separate clinic. We have found that homeless drug users are concerned about their health and generally keen to accept vaccination if it can be offered opportunistically when they are already consulting about a more pressing issue.

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How would patients like to be addressed? A brief survey

All of us who see patients have to call them somehow, and most will have long since given up on asking how they prefer it. We distributed 151 questionnaires among patients of our small, urban, deprived surgery. Most of them (85.4%) preferred first names. This did not vary with age, but our sample was too uniformly white and poor to comment on social class or ethnicity. Doctors seem unlikely to cause offence by using first names.

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To integrate or not to integrate?

Jewell addresses an important issue in questioning the benefits and risks of closer integration between the primary and acute care sectors.[1] In a desperate search to explain poor health system performance, many commentators have seized upon the lack of vertical integration in the UK as A Problem Needing a Solution.

At face value, they are correct. Of course it is essential that from the patient's perspective care is delivered in as seamless a way as is possible. However, I wonder if those who call for

closer integration really understand the functions of primary and secondary care. Certainly, there is little evidence that Honigsbaum,[2] really grasped the role of the generalist, although earlier commentators, such as Margaret Stevens,[3] seemed to have more insight into the issues. I suspect that advocates of integration see the two sectors as existing on a single continuum, with primary care at the 'simple task' end of the production line and hospital-based care at the 'complex task' end. This world view dictates that closer integration is a desirable task and an easy one to undertake.

I think that this stance represents a fundamental misunderstanding of the complementarity of the two sectors. Primary care is a philosophically, structurally and functionally distinct part of the health system. The differences are not historical accidents, or examples of professional protectionism. On the contrary, the emphasis that a primary care practitioner places on generalism, holism, coordination and the capacity to deal with uncertainty, benefits patients and the health system in the same way as the specialised, reductionist and episodic modus operandi of the hospital practitioner.

For everyone's benefit, let's celebrate the differences, rather than attempt to eliminate them.

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New concepts in screening

Dr Muir Gray's account of screening ignores possible harmful effects of screening healthy people.[1] Some of these are obvious, such as the example he cites of perforation of the bowel during colonoscopy. Others are much harder to recognise. For instance, it is difficult to believe that the emphasis on finding disease could not be having an effect on the nation's consciousness of health and suffering. The implicit message is that life is fraught with dangers called diseases, and it's doctors that can help you dodge them. We already live in a health-obsessed, or rather disease-obsessed, over-medicalised culture: any conversation overheard in the high street will tell you that. Combine this with the boredom and stress that also characterises our society and you have a potent cocktail for anxiety focused on disease. We are then in danger of mistaking life for an obstacle course — a process of dodging diseases by having health checks. This is hardly healthy. How much screening and the whole risk factor story contributes to this we cannot know: Dr Muir Gray does call for better knowledge. In the meantime, if we must screen for some of the obstacles on life's journey, it behoves us to place at least equal emphasis on helping people towards a life well lived. Perhaps you ask: is that our job? If our first priority is to do no harm, then it must be.

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Chlamydia screening in primary care

Pippa Oakeshott recommends referral to genitourinary medicine (GUM) for partner notification,[1] but we would question how feasible this would be in the context of a national chlamydia screening programme. There is much concern about the long waiting times for GUM appointments[2] so an alternative would be for partner notification to be performed in primary care. Opportunistic screening for chlamydia is routinely performed in this practice.[3] Over a 6-month period a trained health visitor undertook the role of partner notification and results showed that partner notification was completed in 10 out of 11 cases. By contrast, since the service was withdrawn and people had to travel to a GUM department, only 22 out of 40 detected cases received any partner notification. Our conclusion is that partner notification is feasible in primary care if resourced properly.

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Advanced Access

We welcome the recent evaluation of Advanced Access as reported in the Journal.[1] We were interested to read that telephone triage was regarded as the most and the least successful intervention. In our study on telephone triage the practice did not 'advertise' the operation of a triage service.[2] Mostly it was unnecessary to triage patients due to the ready availability of appointments. Only when all available appointments were taken was it necessary to fall back to negotiation with the patient. Had all patients been triaged it is possible that some patients would have made a habit of accessing care by telephone rather than by seeking appointments.

In relation to the impact on older patients we recently surveyed 900 patients receiving telephone consulta-