

closer integration really understand the functions of primary and secondary care. Certainly, there is little evidence that Honigsbaum,<sup>2</sup> really grasped the role of the generalist, although earlier commentators, such as Margaret Stevens,<sup>3</sup> 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.<sup>1</sup> 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,<sup>1</sup> 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<sup>2</sup> so an alternative would be for partner notification to be performed in primary care. Opportunistic screening for chlamydia is routinely performed in this practice.<sup>3</sup> 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.<sup>1</sup> 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.<sup>2</sup> 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-

tions. The questionnaire included the Patient Enablement Instrument (PEI), a measure of the patients self-reported ability to cope with illness following a consultation. The results suggest older patients are not disadvantaged by telephone consultations. In fact allowing for greater disability and chronic illness among older patients there was no difference in PEI scores between groups older and younger than 70 years. However, a local evaluation at practices operating a variety of Advanced Access ideas suggests that such practices are experiencing a greater influx of 'walk-in' cases (17%) perhaps because getting through on the telephone is more difficult! Patients may be responding by presenting themselves in person making nonsense of efforts to contain workload.

Finally, health-care assistant facilitated, open access, 3-minute GP consultations have been trialed in a deprived inner city community in our region. An evaluation suggests that this innovation successfully resolved access problems and was seldom abused. Our impression is that Advanced Access is a complex intervention and in some practices, and for most patients, is viewed as an improvement.

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## A short walk! A feasible fitness test for general practice

We read with interest the study by Little *et al*<sup>1</sup> comparing three approaches to increase physical activity in at-risk

patients. We agree that further research is needed to clarify the role of fitness assessment in exercise promotion in general practice. It was noted that the 6-minute walk test<sup>2</sup> was the more reliable measure used, but there were some practical difficulties with its use in general practice.

We would like to propose the shuttle walking test (SWT) as an alternative form of fitness testing. The SWT was developed to measure fitness in patients with respiratory disease.<sup>3</sup> More recently it has been used in patients before and after cardiac rehabilitation, either following cardiac surgery<sup>4</sup> or pacemaker insertion.<sup>5</sup> It has also been used to monitor functional capacity in patients with chronic heart failure,<sup>6</sup> cancer<sup>7</sup> and chronic low-back pain.<sup>8</sup>

A significant correlation in the prediction of maximal oxygen uptake has been shown between the SWT and conventional treadmill testing.<sup>9</sup> In patients with chronic heart failure,<sup>10</sup> the SWT has been shown to predict event-free survival at 1 year better than the 6-minute walk test.

The SWT consists of a series of signals played on a cassette tape. The patient walks at a steady pace along a 10-metre course, aiming to turn around a cone at each end when the signal is heard. At the end of each minute the speed of walking increases. The test is terminated when an individual is too breathless to maintain the required speed. Fitness is recorded as the total distance walked during the test.

The test is easy to administer, requires little equipment and only one member of staff to run. We believe that this makes the SWT an attractive option when considering possible fitness tests for use in general practice.

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## Correction

In the July issue, in Neville R. E-mail consultations in general practice [Letter] (*Br J Gen Pract* 2004; **54**: 546) the following authors should have been listed:

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In the June issue, in Gill PS, Quirk TP, Mant JW, Allan TF. The use of lipid-lowering drugs across ethnic groups in the secondary prevention of ischaemic heart disease: analysis of cross-sectional surveys in England (*Br J Gen Pract* 2004; **54**: 442-443) Terry P Quirke was incorrectly cited as MRCGP. His correct qualifications are MBBS, MPH.