

Pulse has just published the results of its patient survey, conducted in partnership with Newcastle and North Tyneside local medical committee.<sup>2</sup> Questionnaires were completed by 9812 patients attending for consultations at general practices throughout the UK during May and June 2005.

The results show emphatically that patients are more concerned with being able to see a GP they know and trust than with getting a quick appointment. Just 7% of patients said that if they needed to see a doctor they would prefer to have an immediate appointment at a walk-in clinic — compared with 79% who said they would rather wait up to 48 hours to see a GP at their own practice. Some 89% said having continuity of care from their GP was important to them and 90% said it was important for the GP treating them to know their family history.

Moreover, 64% of patients said they could get an urgent appointment with their GP within 6 hours and a further 12% by the following day. Some 76% said it was usually possible to get a routine appointment with the GP of their choice 'within a reasonable time'.

The Government's obsessive pursuit of its so-called 'patient choice' agenda is missing the point entirely. GPs are delivering continuity of care alongside the fastest access that is feasible in an under-doctored NHS.

No doubt ministers are right when they claim that patients want faster access to primary care. But what they have failed to recognise is that, above all else, patients want continuity of care from a GP they know and trust.

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#### REFERENCES

1. Fitzpatrick M. The Blair backlash. *Br J Gen Pract* 2005; 55: 809.
2. *Pulse*, 17 September 2005.

## Medical benefits

Alec Logan is wise to warn against

collusion with commercial interests and misplaced hopes in the benefits of medication.<sup>1</sup> But what about avoiding the risks of a highly selective review of the scientific evidence about medication? By citing only AD2000 and the Petersen study of mild cognitive impairment he confuses two issues. There are many trials of cholinesterase inhibitors in Alzheimer's disease, all of which are methodologically limited (AD2000 included), and MCI is not the same as Alzheimer's disease — some would argue that it does not really exist.

The NICE technology appraisal committee reached the judgement that the cholinesterase inhibitors do 'work' — that is, they produce visible and measurable short-term benefits for some individuals with dementia. The controversy that the NICE technology appraisal committee triggered arose because it concluded in its preliminary report that the cholinesterase inhibitors were not cost effective, using a method of economic analysis (Quality Adjusted Life Years) that is itself controversial and contested.

The NICE clinical guidelines development group, working in parallel with the technology appraisal committee, is conducting its own analysis of medication benefits and the economics of the cholinesterase inhibitors, including a systematic review of patient perceptions of benefit. Two important scientific issues are: How can we measure and cost the deferment of disability in a progressive neurodegenerative disorder? What are the characteristics of those who appear to benefit from these medicines, which might allow targeting of treatment in a difficult-to-diagnose pathology?

General practitioners may be able to contribute something useful to the answers, through our close engagement with people with dementia, and with the emerging research networks focussed on neurodegenerative disorders. We also have the ability to influence spending on social care, through joint budgets at PCT level, but we do not need to polarise medication versus social support in a simplistic and counterproductive way.

Our viewpoints are influenced by what we do, creating much scope for hidden agendas and conflicts of interest, so confession is in order. I am a member of the Medical & Scientific Advisory Committee of the Alzheimer's Society, and of the NICE dementia clinical guidelines development group. I have received unrestricted funding from the pharmaceutical industry to carry out non-drug research in the dementia field, and I am associate director of the National Coordinating Centre for Neurodegenerative Disease and Dementias research networks.

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#### REFERENCE

1. Logan A. When the drugs don't work. *Br J Gen Pract* 2005; 55: 639.

*Steve Iliffe is right to declare competing interests here. We thought that there was a note at the heading of this section reminding authors to do so, but it had mysteriously vanished. It has been reinstated this month. Ed.*

#### Corrections

Teunissen D, van Weel C, Lagro Janssen T. Urinary incontinence in older people living in the community: examining help-seeking behaviour. *Br J Gen Pract* 2005; 55: 776–782.

*Figure 1. 314 = women interviewed, and not men interviewed, as stated.*

*Table 2. The percentage of men who sought help should be 46, and not 4, as stated.*