Letters

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Single-handed or group practice, quality of care and patient satisfaction

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The Royal College of General Practitioners recently produced a profile of general medical practices in the UK.[1] This stated that there are currently about 10 500 practices in the UK with an average list size of 6000 patients. Of all practices in the UK, 22% were single-handed in 2004. The paper also illustrated the accelerating trend towards multi-partner practices in the UK. In 1991, practices with two or more partners comprised 68% of all practices in England and Wales; by 2004, they had increased to 77% of the total.

What implications have these changes in practice structure for patients in the UK? The Fifth Report of the Shipman Inquiry notes that a review of the literature over the last 10 years suggests that there is no definitive evidence that the clinical performance of single-handed GPs is inferior to that of their colleagues in group practice.[2] It adds that it seems that no single type of GP practice can claim a monopoly over high quality clinical care[3] and that there is no association between the size of a practice and the quality of care that it provides.[4] However, it mentions that there is a large weight of evidence to suggest that patients favour single-handed or small practices. It reports a 1995 study,[5] which provided evidence that patients prefer smaller practices, practices with personal list systems and non-training practices. A later study confirmed this finding; smaller practices were seen as being more accessible and achieved higher levels of patient satisfaction.[3] Therefore, the implication is that the increasing size of practices in the UK may lead to reduced patient satisfaction.

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A clear response

The credibility of a medical journal does not depend on how incomprehensible the articles are that are included (letter from Remco P Rietveld defending his research on treating conjunctivitis with fusidic acid).[1] If authors responses are to be published they should at least make sense to your readers! When teaching critical appraisal of journals to GP registrars I always tell them to read the response letters some weeks later as often they are very interesting for feedback purposes. Rietveld's response was amusing and confusing but certainly not illuminating!

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Plastic fantastic

I was very interested in the piece by Mike Fitzpatrick on the downgrading of men,[1] which I basically agreed with.

However, I was surprised that he mentioned the use of metal vaginal speculae in the examination of women. My practice discontinued these a long time ago, after an accidental transfer of infection (Trichomonas) in spite of sterilisation. Since then we have always used plastic ones; these are of course disposable, and I am certain most patients find them more acceptable and much less threatening. They are not expensive.

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1. Fitzpatrick M. GPs can no longer claim to be gatekeepers of the NHS. *Br J Gen Pract* 2006, **56:** 83–84.

Letter response

My impression is that David Church[1] feels isolated and unskilled for the local reasons he describes. And I imagine, along with most other GPs involved in substance misuse, I would feel similarly were it not for the certificate course, a good practice team, a PCT commissioning an enhanced service, and a supportive local specialist service.

The importance of training in this regard, such as the RCGP certificate course, cannot be over-estimated. This is clearly much needed since few of us

learned about substance misuse at medical school or during GP training, and yet, even years ago over 50% of the GPs in Strang's[2] survey had seen someone with a substance misuse problem in the preceding 4 weeks.

The RCGP substance misuse unit has set up a two stage certificate course to cater for both the generalist (part 1) and specialist GP (part 2 certificate). This course is mapped to the Drug and Alcohol National Occupational Standards (DANOS) for GPs and in order to complete the certificate candidates need to complete the two user friendly substance misuse e-modules on www.doctors.net.uk. To date, 770 GPs have completed the full Part 1 Certificate since its inception June 2004. I wrote in the August 2005 *BJGP* letters section[3] that 4000 of these e-modules had been completed; now it is almost double at over 7500. So there are currently over 2000 more GPs who have completed both of the e-modules (harm reduction and treatment who just need to attend a face-to-face event to be issued with the full Part 1 Certificate. With regard to training in substance misuse, things are getting better.

But, as David highlights, there are often problems at the secondary–primary care interface; hence the need for training of secondary care providers too (particularly A&E and hospital discharge teams). However, it's not just the lack of seamless care when a patient is discharged from hospital that causes problems (especially on a Friday evening it seems), but many patients on a script for substance misuse that need to be admitted to hospital, for example for serious sepsis, are unwilling to go or stay because their script is not maintained at its usual level.

I would also like to emphasise the need for primary care to commission GP and specialist services that are supportive of local populations and care providers so that this valuable work can be further mainstreamed. Perhaps David Church could consider sending a copy of this reply to his local PCO chief executive and director of public health!

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Vitamin D supplementation needs consistent and planned approach

We read with interest the results of the questionnaire survey undertaken by Metson[1] highlighting the low percentage of practices in the Thames Valley and Lambeth areas that are routinely supplementing infants with vitamin D.

In Bristol, GPs have been reporting increasing numbers of adults with osteomalacia and children with rickets or vitamin D deficiency, primarily in our Somali population. This group, made up primarily of migrants seeking asylum or being granted refugee status, has rapidly grown in the city over the last 5 years. They are particularly at risk due to the combination of black skin, veiled dress in women and socioeconomic disadvantage. A recent review of cases has indicated mostly profound deficiency in those presenting with symptoms and a high prevalence of asymptomatic deficiency in the children of cases.

The poor rate of routine supplementation is not surprising considering the inconsistency between recommendations currently available from the Scientific Advisory Committee on Nutrition (SACN)[2] and the National Institute for Health and Clinical Excellence.[3] We understand that discussions are underway to address this inconsistency (SACN, personal communication, 2006). The low supplementation rate is compounded by the limited availability of suitable preventive preparations. Following the withdrawal of mother's and children's vitamin drops, formerly part of the Welfare Foods Scheme, there has been an absence of easily affordable over-the-counter preparations. The Welfare Foods Scheme will be replaced by Healthy Start, although the launch date and content of the new programme remain to be finalised. In the meantime, we have been preparing local treatment and prevention guidelines in which we will be recommending the prescription of vitamin D supplements for at-risk pregnant women and nursing mothers and their infants up to the age of 5 years. Initially, we will be targeting those in our Somali population and patients with a positive family history of osteomalacia or rickets.

The recommendation by Metson and colleagues for a publicity campaign to encourage vitamin D supplementation is to be supported, but only in the presence of both consistent national guidance on the population groups appropriate for supplementation, and following the provision of easily available supplement preparations.

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Competing interests

The authors have stated that there are none.

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