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'We'll just organise some tests' must be one of the frequent clichés of modern medicine. Ordering tests is something we do all the time, one of the three major outputs of primary care that cost money, yet it's an aspect of work that we question little and understand less, and it's good to be able to shed a little light on the subject. Start with the clinical prediction rule on page 606, where the authors have quantified the effect of treating patients with urinary symptoms on the basis of dipstick results. The effect of following the rule could be to reduce some antibiotic use, but this will mean not treating some women with infections. As they say, the aim is not to target antibiotics perfectly, but to do so more appropriately. The paper on page 587 reminds us of another risk of doing tests; here some patients felt stigmatised by finding that they were positive for *Chlamydia*. Then there are X-rays. In the past GPs have often been criticised for the numbers of X-rays ordered that turned out to have negative results. The standard answer has always been that negative ones are often useful, and the study on page 574 has confirmed that this is so, with the authors concluding that some of the negative X-rays meant hospital admissions avoided. They also recorded the reassurance that negative X-rays could provide, but pointed out that the doctors were more likely to be reassured than the patients themselves. The study on page 570 found that 23% of patients diagnosed with lung cancer were found to have had negative chest X-rays in the preceding year. The leader on page 563 sums it all up with a warning that with improved access to a wider range of imaging techniques, we have to remember at all times that they are not infallible. We must take care not to be seduced by the technology into believing that it will always provide us with perfect answers.

But it is the changing landscape of primary care in England that is likely to be the major preoccupation for GPs in the immediate future. On page 632 Elizabeth Woodroffe has summarised the arguments that much of the work of general practice can be taken over by nurses. Paul Hodgkin presents a very different view on page 634, arguing that primary can make great strides but needs much better investment. In the leader on page 565 Allyson Pollock and David Price argue that the encouragement of commercial operators into primary care is going to lead to a deterioration in quality. The Department of Health disingenuously responds that while the NHS pays it cannot count as privatisation, and that primary care has always been run as a business. But the difference is that up till now those running the businesses always also dealt with the patients. None of us know what the consequences will be of transferring to a managed, employed, and potentially casualised workforce. Allyson Pollock may be being alarmist, but her earlier warnings about the consequences of PFI have been largely confirmed. The last few years of financial plenty will be coming to an end soon. PCTs, faced with tighter budgets in the future (together with some unavoidable commitments, most obviously the long-term bills to fund the PFI built hospitals) will find it difficult to avoid going for the lowest cost primary care contracts. That leaves me with two thoughts. First, Barbara Starfield's work has provided a highly persuasive argument that more investment in primary care is an essential component of an effective healthcare system. If primary care starts to fail, the effects will be felt not in primary care, but in secondary care, and nobody will see it as coming from failing primary care. Second, I have no doubt that many GPs will be happy to work as salaried doctors in managed systems, just as there are already others keen to become employers. But for those keen to continue working in a traditional relationship with patients, and outside structures managed by corporations, the future may present them with an uncomfortable choice. Leaving the NHS to become wholly private GPs is one possibility, and if that happens on a large scale it would amount to wholesale privatisation. In case any readers think that is really alarmist, just remember: that's what has happened to dentistry in large parts of the UK. The government, keen to push forward so-called reforms, will dismiss such suggestions not simply as alarmist but as conservative, self-seeking alarmism. Personally, I am old enough now to worry about such things more as a user than a supplier. I want there to be a system of primary care staffed and run by trained generalists still in place in the next few years, when I expect to have to use it — and if I have to pay for it privately I shall do so.

David Jewell
Editor

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