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July Focus

Last month's articles about the UK contract for GPs, especially the editorial from the New Zealanders, have produced a response in the form of letters (page 580) and an answering leader from Martin Roland (page 525). Roland is much more positive about the effects than Mangin and Toop were, but he also has some concerns, including the warning that the rewards from the activities in Quality and Outcomes Framework must not be allowed to dominate pay. The letters present points of view to support either side of the argument.

One general concern is that the target-driven approach encouraged by the contract makes personal continuity less likely. The editorial on page 527 reminds us why it is so important not to let personal continuity vanish altogether. For the small team that produces the *BJGP*, it's hugely encouraging to know that it's being read and that some feel strongly enough to respond so quickly that, unusually for us, the responses appear in the next issue. Nor is any of this likely to be the last word.

While this may be the most important issue in UK primary care, it will be a long time before we can be sure what the long-term effects of the changes are. With half an apology for using such a familiar quotation, it is a reminder of Zhou Enlai's answer when asked what he felt about the French Revolution: 'It's too early to tell.'

Meanwhile, we continue to struggle with other familiar clinical problems that are not going to go away. Primary care researchers are engaged in high quality work to find clear, simple procedures that will help us decide when to prescribe antibiotics. A test for bacterial infection, completely new to me (procalcitonin), turns out to be no better than C-reactive protein (page 555). Both are associated with radiological changes suggestive of pneumonia; unfortunately neither has a high enough predictive value to be a reliable basis for for deciding whether or not to prescribe.

Hay and colleagues on page 530 report that the clinical rule they published in 2004 didn't work as well as they had hoped when tested on a different population — disappointing. Even without simple tests, GPs are getting something right. The causes of LRTI on page 547 confirmed that bacterial causes (most often *Streptococcus pneumoniae*), are more often associated with pneumonic changes than viral causes; admission to hospital was more likely in patients with pneumonia or pneumococcal infection. How the GPs identify those with pneumonia is still, however, a matter of speculation.

The study of encounters with sick children on page 538 found that the feature most likely to predict serious illness was the doctor feeling that 'something was wrong'. This feeling will probably be familiar to many GPs, but it feels like another 'black box'. Without clearer understanding it's difficult to teach young doctors what it is, or how to respond to it. For the time being, and perhaps for the indefinite future, it looks sensible to try to be aware of it, and encourage each other to trust it better as a more or less reliable clinical feature that we act on.

Oh, and when, in the depths of winter, you are feeling overwhelmed by all these patients with their coughs and colds, remember that the ones we see are only a small proportion of the total, and that most people with such symptoms continue to manage their own symptoms without troubling us (page 561). For every Norman Gland (page 592), who makes our hearts sink (page 584), there are lots of stoics out there.

David Jewell
Editor