Julie Mytton
Specialist Registrar in Public Health
University of the West of England, Bristol
E-mail: Julie.Mytton@uwe.ac.uk

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Screening for peripheral vascular disease

Campbell *et al*'s study of targeted screening for peripheral vascular disease (PVD) in patients with hypertension aged 60 years or over[1] yielded, as they acknowledge, a surprisingly low prevalence of 8% with PVD, as defined by an ankle-brachial pressure index ≤0.9. Leng *et al*'s previous Scottish study of 11 practices revealed a prevalence by the same definition of 18.2% for participants aged 55 to 74 years.[2] I have also recently reported a prevalence in hypertensives of 20% from my practice (mean age 70 years) as part of a study of the interarm blood pressure difference as an indicator of PVD,[3] and also showed that the use of a simple tiptoe stress test[4] was feasible and increased the overall detection of prevalence to 25%.

These prevalences are significantly higher than Campbell *et al*'s finding and would clearly make a stronger case for targeted screening in primary care. The authors assert that their practice prevalence rates for hypertension are similar to average Scottish figures, yet the study profile suggests a prevalence of hypertension of 28% in their over 60s. Scottish public health data suggest a prevalence 33% for adults aged over 16, and that 75% are hypertensive above age 75.[5] Other recent estimates for prevalence of hypertension exceed 60% in the over 60s.[6]

Therefore we suggest that the prevalence of hypertension was low for the age group included in this study, which would suggest that many cases of PVD have gone undetected as they were not included in the study. Consequently, the case for targeted screening has been understated and further work is required. This should include assessment of the peripheral circulation with exercise.

Chris E Clark
School Surgery, Fore Street, Witheridge, Tiverton, Devon, EX16 8AH.
E-mail: chris.clark@gp-L83023.nhs.uk

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QOF

The views contained in the editorial written by Professor Les Toop and Dee Mangin of the University of Otago, New Zealand, in the *BJGP*[1] coincide to a very large degree with those of some of the Executive members of the National Association of Primary Care. That is: the very nature of professionalism, professional values, and the concept of good care (as understood in GP training) are being corroded by the GP contract's Quality and Outcomes Framework, as is the patient-centred ethos of general practice.

The article draws attention to Downie's description of the characteristics of a profession that underpin good care: a credible profession must be independent of the influence of state or commerce; disciplined by its own professional body; have claim to and be actively expanding its unique knowledge base; and concerned with the education of its members.[2] It is clear that as a result of the introduction of the GP contract, the first criterion has been swept aside, maybe unwittingly. With the requirement that from 1 August 2007 all those who wish to become a GP principal must undertake the MRCGP examination, there is hope that the second and fourth criteria will in time be universally met. Revalidation should address any failure in relation to the third criterion.

It is unfortunate that many practices failed to keep detailed clinical patient data, and it is this failure into which the QOF has made some serious inroads, but information which is merely used for accountability purposes and is not actively used as knowledge to inform and improve patient care, both for individuals and wider populations, is equally meaningless. There are opportunities to convert this information into knowledge about patients' health and wellbeing, and to assess the impact of interventions to measure outcomes. The profession itself should be driving this and should be seeking to select targets based on local need. What the QOF has yielded to date should be used positively by the professionals themselves, as well as at PCT level and nationally, to understand the value of interventions and trends in disease. Where is the wisdom of leaving such powerful information untapped on individual clinical systems?

Equally, we agree that damage has already been done in allowing greater status to be given to what is written and coded than to what is spoken in the patient–doctor relationship. The greatest challenge facing medicine today, as the article says, is for it to retain or regain its humanity, without losing its foundation in science. Medicine by numbers completely undermines the humanity of its delivery.

One of the possible ways through is for the profession's leaders to negotiate the alternative approach advocated in the article. Let us hope they can do so.

Maggie Marum
Consultant, NAPC
E-mail: Maggie@napc.co.uk

James Kingsland
NAPC Chairman

Kenneth Scott

Nav Chana
London Deanery

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