The end is not nigh

Roger Jones'[1] gloomy prognostications about general practice and the health service show that fashion is cyclic. Sixteen years ago Duncan Keeley, writing in the *BMJ*, was equally anxious about the future of general practice and even predicted Professor Darzi's polyclinics.[2] In the meantime general practice has flourished. Each contractual shift has induced a temporary dip in job satisfaction and a sustained increase in income, making British GPs the highest paid family doctors in Europe. A revolving door effect has meant that for every task acquired (like chronic disease management) another has been shed (like out-of-hours responsibilities) making work more intense but shorter in duration. GPs may grumble about being industrialised but they mostly accommodate to change and assimilate it, and get on with the job.

It is always tempting to portray GPs as doughty fighters for personalised and continuing care, struggling against the policies of insensitive and ignorant governments, but outsiders will see this as merely a disingenuous and self-serving ideology. Perhaps we should think uncomfortable thoughts rather than simplistic ones. First, the contractual relationship between general practice and the NHS inhibits investment rather than promotes it, leaving us under-equipped. Second, this results in a failure to modernise general practice fast enough to keep up with the expansion of medical knowledge and technology, in a rapidly changing society. Third, the gatekeeper function has all but collapsed in some places and in some clinical domains; at least a quarter of GP referrals to hospital chest clinics could be dealt with in general practice[3] (if it were more skilled and better organised), and 40–80% of ENT referrals may be similar.[4]

If these thoughts are right, the position is untenable, but I cannot see how GPs can escape from it by enhancing their communication skills or claiming some special 'biopsychosocial' understanding that on closer examination looks quite superficial. Roger Jones is right that tenacity, commitment, and imagination are needed to sustain good quality general practice; but without investment in skills and technology, practices will not assimilate current changes. A systematic approach to increasing skills demands time rather than money, and is perfectly possible to do within practices. Investment in technology is a tougher decision but, in my view, the question for practices is not: 'Can we afford to buy an ultrasound scanner?', it is: 'How can we not?'.

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REFERENCES

1. Jones R. Dismantling general practice. *Br J Gen Pract* 2007; **57 (544):** 860–861.
2. Keeley D. The future of general practice: personal care or the polyclinic? *BMJ* 1991; **302(6791):** 1514–1516.
3. Gilbert R, Franks G, Watkin S. The proportion of general practitioner referrals to a hospital respiratory medicine clinic suitable to be seen in a GPwSI respiratory clinic. *Prim Care Respir J* 2005; **14(6):** 314–319.
4. Nocon A, Leese B. The role of UK general practitioners with special clinical interests: implications for policy and service delivery. *Br J Gen Pract* 2004; **54(498):** 50–56.

Dismantling general practice

'Dismantling general practice' was a sobering paper, indeed.[1] I note that Roger Jones' earliest reference is dated 1974. This process was initiated long before this, with the instigation of merit awards for a proportion of consultants, the purchase and sale of goodwill in general practice being made illegal and case notes becoming the property of the Minister of Health — at the very outset of the NHS.

So what kind of jewel are we talking about? The fantasy of the jewel came much later — perhaps it would be charitable to suggest that Bevan was confused by carats and carrots? He certainly rejoiced in his successful use of the latter when devising merit awards, claiming publicly that he has ' … stuffed their mouths with gold.' — his words, not mine. And he was greatly encouraged by the words of a distinguished physician who told him that the GP was '... the doctor who had fallen off the ladder of success.' To complement the carrot, of course, he used the stick on GPs in effectively confiscating their hard-earned (or dearly-borrowed) investment.

Added to this disgraceful employment of bribery and blackmail, by destroying the privacy of case notes he ensured the ultimate demise of the very core of top-class general practice — the trust underlying the precious doctor–patient relationship.

I do not very much care for having become a patient. But worse is having to pay more and more tax to fund this sorry dismantling.

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REFERENCE

1. Jones R. Dismantling general practice. *Br J Gen Pract* 2007; **57 (544):** 860–861.

Supporting self-care in general practice

In their discussion of the complex issues around supporting self-care in general practice, Greaves and Campbell state that a prerequisite is '... that the initiative has the full support of the healthcare team.'[1] We agree that this is a key to achieving optimal care. Our recent experience in the early stage of a community-based trial of home blood pressure monitoring highlights the importance of involving both patients and their GPs.

We are currently carrying out a randomised controlled trial in 360 patients who have had a stroke. The aim is to see if home blood pressure monitoring with nurse-led support is associated with lower systolic blood pressure after 1 year. Three foundation year two doctors helped with the initial planning of the trial and implementation of the pilot study.

Twenty baseline home visits were carried out with 10 patients randomised to the intervention group and given home blood pressure monitors. One month

follow-up visits showed that patients had few problems using their home blood pressure monitors and knew that their target for home blood pressure is <130/80 mmHg[2] (as we printed this on labels which were stuck to monitors). However, when patients initially consulted their GPs and showed them their recordings of consistently well over-target home blood pressures, no changes were made to their antihypertensive treatment.

We have therefore developed additional trial information to post to participants' GPs. This includes information on home blood pressure targets (10/5 mmHg lower than clinic blood pressure[2]) and current antihypertensive guidelines.[2] We also developed information for patients with a note for their GP to facilitate discussion about blood pressure targets and to support home blood pressure monitoring. Preliminary reports from both GPs and patients suggest this has been beneficial and led to agreed treatment changes and improved blood pressure control.

As Greaves and Campbell point out, 'Only a minority of people with hypertension achieve target levels for control'. Stroke patients are often highly motivated to consider self-care interventions which will reduce their risk of having another stroke. For those who wish to monitor their blood pressure at home, the support and involvement of the primary health care team is crucial.

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REFERENCES
1. Greaves CJ, Campbell JL. Supporting self-care in general practice. *Br J Gen Pract* 2007; **57(543):** 814–821.
2. Williams B, Poulter NR, Brown MJ, *et al*. Guidelines for management of hypertension: report of the fourth working party of the British Hypertension Society, 2004-BHS IV. *J Hum Hypertens* 2004; **18(3):** 139–185.

Patient choice

The fascinating paper by Bryant *et al*[1] on patient choice highlights the impact of healthcare policies on human behaviour.[1]

One area that particularly interests me is the concept of choice in relation to abortion and how it may affect decision making.

If 'framing a decision as a choice can enhance the perceived value of a particular option',[1] perhaps the default state for a society in dealing with crisis pregnancy shifts towards abortion and more women may opt for it.

I am at the anti-abortion end of the spectrum of opinion on this issue and realise that most GPs pitch camp elsewhere. But it strikes me that most people agree it would be better for those women (an unknown percentage) who have a termination only to regret it, to somehow be enabled to make a different choice if it is right for them.

Research into this area of decision making will undoubtedly be challenging, but it may help some of those women for whom pro-choice is no choice at all.

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REFERENCES
1. Bryant LD, Brown N, Bekker HL, House A. The lure of 'patient choice'. *Br J Gen Pract* 2007; **57(543):** 822–826.

Continuity of care

I read with interest the views of James Willis[1] on the need for continuity of care: it is certainly an area where there should be increasing debate in what is otherwise an age of increasing fragmentation of medical care. I think it is important to remember that when a diagnosis is made and a care plan agreed on, it is exactly that, a plan that is agreed mutually between patient and doctor. Therefore, ones prior knowledge and ability to relate to the patient in questions are extremely important.

However, I would also argue in an age of protocol-driven health care that there are perhaps more important things going on in a consultation for which we don't readily have the scientific measurement. Our instincts as physicians and ability to tune into unconscious communication means that sometimes we quite appropriately run over zealous 'diagnostic algorithms' past seeming trivia, and equally seek to reassure those whose symptoms on the face of it sound alarming!

It is experience and personal knowledge of the patient and family that allow one to deal intuitively with some of these apparently unscientific incongruities that face us all the time in general practice. Furthermore and not insignificantly, by and large, most physicians enjoy continuity of care but, I think equally so, find it difficult to pick up threads in complex cases where patients have seen many different doctors sequentially.

General practice is a vocation where continuity of care enhances the patient's experiences and outcome rather than its 'bureaucratocentric' health care (apologies for neologism).

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REFERENCE
1. Willis J. The publish properly trap. *Br J Gen Pract* 2007; **57(541):** 671.

Correction

In the November 2007 issue of the *BJGP* (volume 57, page 857), the Contents page should have included the following entry:

919 **Viewpoint** — Prescription benzodiazepines and z drugs — the hidden story', Allan Weatherburn.