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November Focus

It is 30 years since the Alma Ata declaration of 'Health Care for All by the Year 2000'. At the time its commitment to universal health care, and the clear statement that it could only be achieved through the establishment of comprehensive primary healthcare felt like a wind of change. It would be easy now to view such thoughts as naïve optimism, but the article on page 806 is by four authors, all of whom have been involved in bringing about fundamental changes to primary healthcare systems in their respective countries. In their analysis of the challenges facing 'Primary health care in a changing world', they examine how many of the principles we take for granted are threatened by social and medical shifts. Trisha Greenhalgh's Pickles lecture on page 798 picks up on the same theme, and identifies trends that we have to take into account: globalisation, modernisation, individualisation, and consumerism. Her lecture ends with a plea that we must try to retain the best aspects of general practice that Will Pickles' life represented — she describes them as core characteristics of old-fashioned general practice — that will be as important dealing with the problems of present and future societies as they were in his day. An affectionate portrait of such a doctor is on page 813. While few of us would feel able to make such commitments to our patients today, we might all hope that we were striving to forge those kind of relationships with our patients. The brief report on page 780 sheds a little more light on what's involved. Surprisingly trust was not independently predicted by seeing the same doctor, but by good interpersonal care, good care from the GP in the past, and any expectation or experience of further follow-up. In other words, all the things that a doctor might do, and a doctor seeing a patient more regularly might be trying to do. Even so, it's a reminder that simply seeing the same doctor might not do the trick, but it's what the doctor does that matters. There is a wonderful vote of confidence about what surgeons in training can learn from a spell in primary care (page 805).

Trisha Greenhalgh also wants clinicians to be leaders in research, as Will Pickles was. Elsewhere in the journal David Mant takes a similar line, in arguing for good observational research to sort out how to use evidence gathered from single disease studies when looking after patients with multiple morbidities (page 755). While applauding the decrease in variability that has been encouraged by QOF, he argues that many of the QOF indicators lack really robust evidence, a point made just as strongly by Mike Fitzpatrick about recommended interventions for patients with alcohol problems (page 815). Some observational data can be gleaned from routinely kept records. Access to medical records has, of late, become more restricted through a well intentioned desire to protect patients' privacy. The consensus document summarised on page 814 recommends a more relaxed approach, arguing that researchers with accreditation, and with contracts that emphasise the need for patient confidentiality can be trusted with easier access. This conclusion is supported by data presented at a conference I attended earlier this year on research governance for biobank studies, where researchers from very different cultures reported patients' willingness for their data to be used by doctors for research purposes (but not, again consistently, if commercial interests were involved — we're back to trust again). Variability, however, is still alive and well, as the article on page 790 illustrates. The authors reviewed studies on back pain where the control group had 'usual care' and found a lot of variation in the definition of 'usual care', at least in the papers where it was described at all. David Mant points out that such variation makes the interpretation of such trials well-nigh impossible, and puts in a plea for more uniformity when conducting such trials (page 755).

Riddle of the month. In Table 1 of the cost-effectiveness study on page 775, an MRI scan of the knee is listed as costing more than double an outpatient attendance. Can someone please explain to me how this happens?

David Jewell
Editor

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