ISSN 0960-1643 (Print)
ISSN 1478-5242 (Online)

May Focus

There is some serious heart-searching in this month's *BJGP*. Managing general practice by the performance indicators in the QOF comes under attack in the piece by Jonathan Richards on page 376. Helen Lester, who remains overall in favour of the process, has some concerns over the long-term effect of the formula on the way that general practice will be seen by future generations of medical graduates (page 376). But it's difficult to predict what general practice will look like at all in the next generation. Edin Lakasing on page 380 is worried about the direction that employment patterns have taken, and the effect it will have on patient care: '... what gain is there in fretting over the quality of out-of-hours services, or advancing the cause of easy patient access to their health records when we cannot guarantee reasonable daytime continuity of care? The risk to general practice is that patients may indeed conclude that their care lies elsewhere, and the Darzi plan will succeed by default.' It's all part of the process of the '... *Industrialisation of Family Medicine*' reviewed on page 384, where Dougal Jeffries sets out the dilemma for all of us. One drawback is that the model of industrialisation we are presented with is itself rather out of date. A more adventurous model, where decision making is pushed from the centre to the periphery is outlined on page 361. Faced with this challenge one group of authors set out to define the essence of general practice, and describe the process on page 356. They conclude that 'The consultation — and how and where it is provided — must be informed by research and evidence, guided by wisdom, and underpinned by values. The current tendency to reject the need for a broadly humanistic approach in favour of a narrow biomedical one needs to be challenged by both the academic and the working GP community ...' Not new of course, as Iona Heath's accompanying editorial on page 316 points out, but important to restate in what she describes as 'the hostile intellectual environment.'

The research this month is a mixed bag, but some points to ways in which we might be able to make progress by using evidence consistently with core values. For instance, the paper on page 322 comparing two different methods to assess guidelines, and using depression as the example, found significant limitations to their use for general practice, and that we should be working to make them more relevant. In the editorial on page 317, two of Europe's most consistent champions of guideline use present a balanced view, with evidence that overall guidelines have improved the quality of clinical decisions in general practice. However, they also agree that guidelines need to be more relevant to both practitioners and patients, and see better collaboration between the different stakeholders as the way to achieve this. Then there is a persuasive discussion paper on page 364, arguing for an approach towards older patients assessing frailty, which can take us 'from organ- and disease-based medical approaches towards a health-based integrative one, and therefore, fits the biopsychosocial model of generalism very well.' Without completely understanding how the concept works, it seemed to me that using the score in order to improve health would require us first to take the holistic view, but then to disentangle it to analyse which elements need to be addressed. If that's right, it really does become a model of good general practice, where we manage to be simultaneously both holistic practitioners and good biomechanics.

Good biomechanics will be keen to incorporate new technologies into their clinical practice. The two linked papers on page 329 and page 336 present the results of a trial giving GPs open access to hysterosalpingography. The intervention didn't have any effect on the primary outcome. The problem here was the familiar one of generalists being cautious at using 'new' tests, particularly for a clinical problem that is only encountered a few times each year. For the few patients whose GPs used open access there was reduced waiting time to treatment, and everyone who had used it valued open access enough to want it to remain in place. Bonnie Sibbald's leader on page 318 draws on a review of access to diagnostic services and is reassuring that (as we would all have predicted) GPs do not, on the whole, use such services inappropriately.

Finally, there is a surprise, and a pointer to the future in the paper on page 344 describing 5 years of data on poor performance. There were few instances of poor performance, but the authors report 26 instances of whistleblowing by GPs about their colleagues. Would that have happened a few years ago?

David Jewell
Editor

DOI: 10.3399/bjgp09X420536