that clinical setting; a commitment to the recognition of the huge efforts made by GPs and other primary care researchers; and a concern that excessive bureaucracy, underfunding, and lack of support by practice colleagues could damage the increasingly impressive profile of internationally successful GP research in the UK. Our main concern was to broaden awareness of how much the RCGP already does to support individual researchers, practice-based research, and the strategy and delivery of the national research agenda. Both the Seamarks and Tudor Hart acknowledge the need for GPs to group up to deliver: 'Multicentre studies on and with participating patients, conducted peripherally by primary care staff with personal knowledge of and responsibility for those patients, and coordinated centrally by groups including both fully trained researchers and experienced primary care staff, provide the only possible sites for research on patients as they actually are, where they actually live, which we must have for guidelines to become optimally effective aids to clinical decisions.'¹ The individual GP researcher is not extinct — they are just working with others across the UK, backed by the RCGP, and advocating for the highest quality research we can deliver at all levels.

Amanda Howe,

School of Medicine, Health Policy and Practice, University of East Anglia, Norfolk NR4 7TJ.

E-mail: Amanda.Howe@uea.ac.uk

Nigel Mathers,

Academic Unit of Primary Medical Care, University of Sheffield, Sheffield S5 7AU.

Steve Field,

RCGP, Belle Vue Medical Centre, 6 Bellevue, Edgbaston, Birmingham B5 7LX.

REFERENCE

1. Tudor Hart J. Clinical research by GPs in their own practices. *Br J Gen Pract* 2009; **59**(560): 214–215.

10.3399/bjgp09X454179

Re: Practice-based research

This correspondence is now closed — Ed.

Future of general practice

The marked contrast between the personal view 'A final g'day to English general practice'¹ and 'Practice, politics, and possibilities'² was striking.

Much of Adrian Elliot-Smith's observations about the changes in general practice may ring true, but his defeatist and world weary acceptance of the demise of urban general practice in this country is far from the mark and surely needs challenging.

Martin Marshall makes an excellent case for concentrating on the core values of general practice (commitment to excellent medical generalism, whole patient care, and the advocacy role of GPs on behalf of their patients and communities) and the need for social marketing to get the message across of the benefits of good local general practice.

We need to recognise that collectively and by working collaboratively we can influence the debate about the future of general practice. We need to get out of our silos. The government and society want autonomous and self-responsible clinicians.³ The government can only set the direction, ensure minimum standards, and help to break barriers that prevent development of good services. As professionals we need to promote creativity and ambition, raise skills, be flexible, pursue excellence, promote excellent leadership and management, and set our own challenging standards of excellence. Our accountability to society will be strengthened by empowering patients and by demonstrating transparency of performance and our commitment to addressing health inequalities.

Perhaps we have been too long cultivating our own garden. It is time to look beyond its hedges and fences because the world will continue to intrude. Unfortunately, Voltaire never told us how to cultivate it successfully.

Julian Law,

Kirkby Community Primary Care Centre, Ashfield Community Hospital, Nottinghamshire NG17 7AE.

E-mail: Julian.Law@GP-Y02181.nhs.uk

By way of biography I work as lead GP for a community enterprise organisation. The practice has been established for a year in a deprived and previously under-doctored area.

REFERENCES

1. Elliot-Smith A. A final g'day to English general practice. *Br J Gen Pract* 2009; **59**(565): 618–620.
2. Marshall M. Practice, politics, and possibilities. *Br J Gen Pract* 2009; **59**(565): 605–612.
3. Cabinet Office. *New professionalism*. Strategy Unit, Cabinet Office, 25th February 2009. http://www.cabinetoffice.gov.uk/strategy/publications/excellence_and_fairness/report/html/new_professionalism.aspx (accessed 11 Aug 2009).

10.3399/bjgp09X454188

Politics and primary care

The August *BJGP* contained articles that run straight to the heart of 21st century UK health care and what must be done to secure the future for the patients. Kath Checkland, Adrian Elliot-Smith, and Martin Marshall are to be thanked for their contributions, that viewed together, frame the scene perfectly.

The commercialisation, atomisation, proletarianisation, managerialism, and contractualism that infests so much of contemporary national life and the health service in particular ought not to go unanswered. Together we can respond effectively, but who will join the fight?

In order to prevail we must be fully and directly engaged politically — that means we must get elected in some numbers. I have committed myself to standing as an Independent as far back as 2006¹ and retired prematurely from general practice in 2008 for that purpose. In the last couple of days Dr Wollaston from Totnes has become a candidate with substantial chances of success — arguably because she is not a typical party politician.

It is my view and I suspect the view of many, that primary health care is best delivered by multidisciplinary, autonomous, coherent teams dealing with defined populations — this is no golden-age idyll, merely the objective reality. Likewise, coherence and collaboration between all sections of the healthcare delivery system

is essential. Competition is the antithesis of care.

The door is wide open. Never has the standing of the political class been lower in the public's estimation. The commentariat is loud in its support for new blood in politics.

There are no excuses. This is the right time to achieve the future that will benefit the patients. Let's have a healthcare professional standing in every constituency.

Steven Ford,
Haydon Bridge NE47 6HJ.
E-mail: mail@stevenford.co.uk

REFERENCE

1. Ford SD. How to become an MP. *BMJ* 2007; 335(7624): 826.

DOI: 10.3399/bjgp09X454197

Vertical versus horizontal integration

I was impressed by Martin Marshall's clearly thought out analysis of the role of general practice in a modern health system,¹ although one might debate the detail. For instance, personally I regret the loss of 24-hour responsibility and only reluctantly accept the strength of his argument in relation to this. However, Marshall's three core principles might be a useful basis for looking at many current problems — and one in particular — swine flu.

The three principles, paraphrased and abbreviated, are that GPs are: medical generalists who are up to date with the evidence; committed to whole person care; and advocates on behalf of their patients.

For swine flu, a vertical approach is encouraged in which services are provided in a uniquely different way for one condition of supposedly over-riding importance. This is unlikely to work well in primary care. Many patients who think they have swine flu have nothing of the sort and are disproportionately or inappropriately worried. A few who are discouraged from consulting face-to-face will turn out to have

meningococcal meningitis and suffer a worse outcome because of the delay in diagnosis. Guidelines and policy have very little evidence underpinning them, and where there is evidence or lack of it this information is not being made available to GPs or to the public. Care of individual patients is taking second place to flattening the pandemic curve and we are doing our patients a disservice if we accept this ordering of priorities without question.

It is, perhaps, not surprising that politicians, the media, and the public have a poor grasp on science and it may not be news to us that many scientists and medics don't appreciate the nature of general practice. However, I find it disappointing that our GP leaders seem, largely without protest, to accept the official policy that reflects a poor understanding of both.

Wilfrid Treasure,
Muirhouse Medical Group,
1 Muirhouse Avenue, Edinburgh.
E-mail: wilfrid.treasure@lothian.scot.nhs.uk

REFERENCE

1. Marshall, M. Practice, politics, and possibilities. *Br J Gen Pract* 2009; 59(565): 605–612.

DOI: 10.3399/bjgp09X454205

Sickness certification

The paper from Wynne-Jones *et al* on sickness certification rates is timely and adds to the evidence on this field in the UK. I note, however, a couple of minor errors with reference to the research we undertook a few years ago in the UK on the same topic.¹ We also collected data on actual sicknotes not, as stated in the discussion, the use of incapacity reports as a proxy. We were able to track consecutive and separate periods of sickness absence from an anonymised database of over 13 000 sicknotes of around 7000 patients in a 1-year prospective sicknote survey across 10 practices. We were looking for data on risk factors that increased the risk of entering longer-term absence and incapacity, but used sicknote data to do

that. The other citation of our work² relates to a secondary analysis of our database where we demonstrated the differential risk of longer-term absence depending on gender interaction in the consultation — and while European data (as the UK is in Europe), it was our 2004 paper that was the first to report the preponderance of mild mental health problems over musculoskeletal disorders as the greatest cause of sickness absence. I presume this is a drafting error, but perhaps it is important to clarify that this paper is further evidence on UK certification practice from records, not the first ever. However, a common problem with our databases is that it is not possible to distinguish those in employment from those on benefit using either of these methods. It is to be hoped that the recent NICE guidance (that recommends this) and the forthcoming introduction of the electronic fit for work note due to replace the MED3 and 5 in 2010, promotes more systematic recording of patients' occupation, work capacity, and role in records, particularly when capacity for work is a subject of the consultation.

Mark Gabbay,
University of Liverpool, Whelan Building,
Quadrangle, Brownlow Hill,
Liverpool L69 3GB.
E-mail: m.gabbay@ntlworld.com

REFERENCES

1. Shiels C, Gabbay MB, Ford FM. Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *Br J Gen Pract* 2004; 54(499): 86–91.
2. Shiels C, Gabbay M. The influence of GP and patient gender interaction on the duration of certified sickness absence. *Fam Pract* 2006; 23(2): 246–252.
3. NHS Evidence. *Management of long-term sickness absence and incapacity for work*. NICE 2009. <http://www.library.nhs.uk/MENTALHEALTH/ViewResource.aspx?resID=310240> (accessed 11 Aug 2009).

DOI: 10.3399/bjgp09X454214

Correction

In the August issue of the *BJGP* we incorrectly published the order of authors, it should be as follows:

Brittain D, Jones M. Music in the waiting room. *Br J Gen Pract* 2009; 59(565): 613–614.

We apologise for this error.

DOI: 10.3399/bjgp09X454223