Using echocardiogram as a screening tool would need enormous resources, would yield high false-positive rates, and is neither practical nor cost-effective. Results of a systematic review by Health Technology Assessment showed that clinical examination along with pulse oximetry had the highest detection rate with low false-positivity rates.⁴ The Pulseox study in the West Midlands is a large multicentre prospective study being conducted to assess diagnostic accuracy and cost-effectiveness of routine pulse oximetry to screen congenital heart defects.⁵

In our study, postnatal examination detected just under half of all infants with congenital heart defects. The 6–8 week infant check by GPs remains an important point of contact for patients as it detected more than a third of infants. The introduction of pulse oximetry as an aide to both these examination checks could increase detection.

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Are 'polysystems' for doctors or patients?

Polysystems are an extension of the London polyclinics transformed into GP-led health centres. Various studies debate the differences between models consisting of single large buildings and 'hub-and-spoke' models. Hutt *et al* ask the question: 'How is primary care best configured?'¹

The King's Fund quotes international examples from countries such as Russia and Cuba, arguing that it is more important to develop new ways of working than to construct buildings, and that new configurations are unlikely to be cheaper than existing systems.² In addition, a report from Australia concludes that in the UK, existing medical practices are responsive and are able to meet community needs.³

In Italy, the national government is in the process of attempting to convince family doctors to sign new contracts requiring many additional medical duties without increased remuneration, as well as considering the creation of new mega-aggregations of professionals within practices covering large populations. At the same time, the government is contemplating a shift of many services from secondary to primary care.

The reaction of associations of GPs is essentially negative. They predict a disruption of the existing structure into micro-groups, problems for patients having to travel considerable distances, and large institutions where there will be longer waiting times, confusion, and loss of doctor–patient continuity, possibly resulting in duplication of services.

Morgan and Beerstecker⁴ indicate that there is no evidence to suggest that very large practices can provide greater patient throughput or diversity of services than is available at the current average English practice. Therefore, a policy to create larger practices may not automatically lead to a transfer of work from secondary to primary care. Also, there is an upper

threshold above which practice size simply creates spare capacity and untapped expertise.

It is most important to consider these data when we see, as at present, multiple national governments calling for new systems of governance for family medicine that involve top-down approaches not agreed to by primary caregivers, by secondary caregivers, or by patients themselves.⁵ It is dangerous for these changes to be pushed by politicians with the aim of achieving financial savings without considering what family medicine was, is, or will become. It is crucial that we remember the WONCA European Definition.⁶

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