Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post as an MS Word or plain text version on CD or DVD. We regret that we cannot notify authors regarding publication. Letters not published in the Journal may be posted online on our Discussion Forum. For instructions please visit: http://www.rcgp.org.uk/bjgp-discuss

Pathfinder status and GP commissioning consortia

If GP-led commissioning is to realise its potential to re-shape the NHS in ways that serve patients better, facilitate care in and around people's homes, and strengthen general practice, GPs and all those working in the NHS need to understand its basic principles. The key rule is that NHS money is now real money. GPs need to be aware that every prescription or referral is a commissioning decision. Until now we hardly felt the consequences of overspending on prescribing and secondary care budgets. How we spend NHS money will now have financial consequences for us. This will revolutionise vocational training when trainees will need much closer scrutiny by practices to ensure they are not wasting money.

We need to teach and demonstrate that:

$$\text{Value for money} = \frac{\text{Effectiveness}}{\text{Cost}}$$

As 'pathfinder commissioners' we have to ask 'why has the government chosen general practice to be given this prize?'. We believe it reflects an appreciation of two key attributes of general practice:

- GPs are trusted by patients as their advocates; and
- UK general practices are generally effective, efficient, and financially prudent.

The former will test our relationships with some patients and it is vital that legislation explicitly deals with higher-risk patients who could damage budgets. Practices too, will quickly understand that their neighbours can financially threaten the whole commissioning enterprise.

Vision is crucial[1] — merely saving and making money is not enough. GP-led commissioning consortia could deliver the high quality outcomes needed for a 'liberated' NHS that truly reduces health inequalities while improving value and effectiveness, and controlling costs. We particularly think that GP-led commissioning could help keep vulnerable older people out of hospital where they languish too often. Other visionary possibilities include:

- Improving primary–secondary care dialogue and joint care;
- Care 365 days a year. We are already some way towards this with a 6-day-week domiciliary GP service for older people in our town of St Helens;
- longer surgery appointments, for example 15-minutes; and
- development of the next generation of leaders of primary care, by using savings to enhance the training of our staff and our successors.

We applaud the College's determination to support the leaders of GP-led commissioning and now we must ensure that we are actually given power and responsibility. If this is done we are confident that English general practice will deliver on the biggest challenge it has ever faced.

John Holden,
Garswood Surgery, Billinge Road, Garswood, St Helens, WN4 0XD.
E-mail: john@holdens.org.uk

Stephen Cox,
Garswood Surgery, Billinge Road, Garswood, St Helens, WN4 0XD.

REFERENCE

1. Roland M. What will the white paper mean for GPs? *BMJ* 2010; **341:** c3985.

DOI: 10.3399/bjgp10X544122

The future of medical education in the UK

The recent editorial by Rees and Stephenson[1] comes at a most opportune time as the healthcare world, in which our future graduates will work, becomes more dynamic than ever. The editorial clearly outlines the major steps in development and the challenges that anyone involved in healthcare education will expect to face in the near future. However, I feel that one vital component needs greater emphasis, and that is the recognition given to the specialty of medical education.

Having started life as a working GP, and through an interest in training and assessment, I have now become a full-time consultant in medical education and I feel that I can see the situation from both sides. What still amazes me is that, despite everyone stating very clearly that the future of our health lies in education, how little notice is paid to the support and development of medical education, how little credibility is afforded to publications in medical education journals, and how little attention is paid to high quality research in the subject; truly a Cinderella within the pantomime of academia.

As a medical educationalist, I have a Masters and a Doctorate in the specialty, but still my colleagues in other academic subjects consider me to have opted out, chosen a soft science, gone for an easy option — I can assure everyone, it is not!

Let's take forward the suggestions from this much needed and welcoming editorial, let's invest in the future by investing in our educationalists; remember as we all get older, we may come to thank these specialists for producing the doctor that is now providing us with excellent care.

Trevor Gibbs,
Visiting Professor in Medical Education and Primary Care, Ukraine National Medical Academy of Postgraduate Medicine, Kiev, Ukraine. E-mail: tjg.gibbs@gmail.com

REFERENCE

1. Rees PJ, Stephenson AE. The future of medical education in the UK. *Br J Gen Pract* 2010; **60(580):** 795–796.

DOI: 10.3399/bjgp10X544131

Medical certification: is it in the patient's best interest?

The paper on 'work-related sickness absence negotiations: GPs' qualitative perspectives'[1] provided invaluable insight into the feelings and perceptions of GPs who are asked by their patients to provide medical certification regarding absence from work. It highlights the vast differences between GPs concerning the provision of medical certification.

The paper also highlighted that several GPs felt that it would be detrimental to the doctor–patient referral if the medical certificate was not provided.[1] However, the question remains 'if a patient was to ask for a therapy that would not be in their best interests should we as GPs still go ahead and prescribe it?' For this reason when issuing a medical certificate would it not be wise for the consulting GP to ask themselves 'am I doing what is in my patient's best interest?'

Several studies have re-enforced the beneficial effects of work and the adverse effects of prolonged unemployment.[2,3] The association of unemployment and an increased Framingham Risk Score, and subsequently, the heightened risk of developing cardiovascular disease has been documented in studies conducted in unemployed men in Poland.[4] In addition to the physical illness associated with long-term unemployment, the psychological consequences are also of considerable significance.[5]

Platt *et al* established that there was a positive correlation between long-term unemployment and suicide rates among men in Italy during the period of 1977–1987.[6] This positive correlation was also supported by a recent study of unemployed men in Japan.[7]

Although in New Zealand this increase in suicide risk has been attributed to confounding factors,[8] one cannot argue the beneficial effects of employment on both physical and psychological health.

Therefore, a healthier population can in turn result in a decrease in surgery visits, hospital admissions, and a reduced strain on limited financial resources with an increase in economic productivity.

Increased sickness absence from work can also result in a greater risk of unemployment.[9] The recent changes to the medical certificate have provided GPs with several options as an alternative to 'you are not fit to work', helping to ensure patients remains in some form of employment. In addition to this there is evidence to suggest that a graded return to work can increase the probability of the patient gaining and remaining in employment.[10]

Although the present system of medical certification has many flaws, the realisation that employment has beneficial effects on health have been known for some time and should remain foremost when making a decision regarding time off work.

Perhaps it would be in patients' and GPs' best interest if this role was taken away from GPs, thereby minimising the possibility of a conflict of interest and reducing the probability of many a dilemma faced by GPs when issuing medical certificates.

Ultimately, it is the authors' view that a medical certificate should be seen as any other medicine that is prescribed. Therefore, it should only be issued if it is truly in the patient's best interests thereby ensuring beneficence and non-maleficence, so that two of the four pillars of medical ethics are respected at all times.

Hardeep Bhupal,
Associate GP, Botwell Medical Centre, Hayes, Middlesex.
E-mail: hkbhupal@hotmail.com

REFERENCES

1. Money A, Hussey L, Thorley K, *et al*. Work-related sickness absence negotiations: GPs' qualitative perspectives. *Br J Gen Pract* 2010; **60(579):** 721–728.
2. Graetz B. Health consequences of employment and unemployment: longitudinal evidence for young men and women. *Soc Sci Med* 1993; **36(6):** 715–724.
3. Leeflang RL, Klein-Hesselink DJ, Spruit IP. Health effects of unemployment — II. Men and women. *Soc Sci Med* 1992; **34(4):** 351–363.
4. Kozieł S, Lopuszańska M, Szklarska A, Lipowicz A. The negative health consequences of unemployment: the case of Poland. *Econ Hum Biol* 2010; **8(2):** 255–260.
5. Latif E. Crisis, unemployment and psychological wellbeing in Canada. *J Policy Model* 2010; **32(4):** 520–530.
6. Platt S, Micciolo R, Tansella M. Suicide and unemployment in Italy: description, analysis and interpretation of recent trends. *Soc Sci Med* 1992; **34(11):** 1191–1201.
7. Kuroki M. Suicide and unemployment in Japan: evidence from municipal level suicide rates and age-specific suicide rates. *J Socio Econ* 2010; **39(6):** 683–691.
8. Fergusson DM, Boden JM, Horwood LJ. Unemployment and suicidal behavior in a New Zealand birth cohort: a fixed effects regression analysis. *Crisis* 2007; **28(2):** 95–101.
9. Hesselius P. Does sickness absence increase the risk of unemployment? *J Socio Econ* 2007; **36(2):** 288–310.
10. Høgelund J, Holm A, McIntosh J. Does graded return-to-work improve sick-listed workers' chance of returning to regular working hours? *J Health Econ* 2010; **29(1):** 158–169.

DOI: 10.3399/bjgp10X544140

GP obstetrics

David Jewell's lament for GP obstetric services is clearly heart-felt and he makes some valid points.[1] But I am far from convinced that his sense of loss, particularly for GP intrapartum care, is shared by the majority of current practising GPs. Moreover, he makes a number of assertions that are open to critical analysis.

It has become common place to blame