they can no longer afford because premiums rise with age. They expect the same service now that they have more need of health care, from the NHS. This may lead to a higher rate of requests for referral to secondary care. It can take a lot of time, patience, and repeated visits to try to educate this group to have more realistic expectations of the service and to keep patients away from unnecessary and expensive secondary care.

In conclusion, we believe that population age, the availability of family support, rurality, and patient expectations may have as much, if not more, of an influence on GP workload as population deprivation. Furthermore, any reduction in GP funding may lead to an inadequate gatekeeper role and increased use of expensive secondary care. We're all GPs and we're all in at the deep end paddling hard to keep afloat.

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Author's response

What is the NHS for? Steven and Jackson give several examples, based on 'idyllic, rural' north-east Fife, including counselling for patients no longer able to afford private medicine, home visiting across the country miles, providing extra support for older patients whose offspring live far way, and the general increased needs of older patients.[1]

All these types of issue, variously reflecting needs and demands, can keep GPs busy, but in the same way that the purpose of the NHS is not just to pay staff, neither is it just to be sure that staff are busy.

It is no news to anyone that increasing age is the main driver of consultation rates in general practice, whether in affluent or deprived areas. Successive GP contracts have been weighted to reflect this. But while GPs serving affluent areas have to cope with the multiple morbidity of ageing, GPs serving very deprived areas are dealing with higher levels of multiple morbidity and social complexity at every age after childhood. GP contracts and workload studies have taken little account of this, partly because workload can only increase so much, and after that, both practitioners and patients have to adapt to what is possible. The maldistribution of GP manpower in the UK, that is worse in England than in Scotland, is an established fact and not a hypothesis.[2] The 'Deep End' title implies the consequent depth of unmet need within everyday general practice in deprived areas.

Many of the issues that concern general practice in the Deep End are similar to those affecting all practices, including the challenges of ageing populations. One reason for focusing on the Deep End is that life expectancy is unnecessarily short in very deprived areas, and as Julian Tudor Hart has shown, well-organised, mainstream general practice can make an important difference. General practice could be better supported to improve health and narrow health inequalities in very deprived areas — not just a 'laudable aim', but a major policy objective of all political parties. This is not the only purpose of the NHS, as Dr Steven and Professor Jackson describe, but the case deserves a hearing, and respect.

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Asymptomatic COPD and NICE guidelines

The continuing discrepancy between national and international guidance is unhelpful for patients, doctors, policy makers, and researchers because the Global initiative for chronic Obstructive Lung Disease (GOLD) does not require the presence of subjective symptoms (cough, sputum production, shortness of breath), whereas NICE guidance states that symptoms are a requirement for diagnosis and classification of chronic obstructive pulmonary disease (COPD).[1] Why does the National Institute of Health and Clinical Excellence (NICE) persist with this discrepancy when there is substantial evidence that reported symptoms are unreliable for diagnosis?

For example, among 5000 people from those included in the Third National Health and Nutrition Examination Survey in the US, 70% of those with undiagnosed early airways obstruction, and up to 50% of undiagnosed stage 3 chronic obstructive pulmonary disease denied having cough or phlegm, and 40% denied a wheeze.[1] A longitudinal study of over 2000 patients with COPD, from 12 countries, found that 'among subjects with severe airflow obstruction, a substantial proportion did not report symptoms'. About 40% of those in the GOLD severe category denied being breathless (modified MRC dyspnoea scale 0 [10%] or 1 [30%]).[2] Likewise, among a large population survey in China of 20 000 people over 40 years of age, 8% were found to have COPD of whom 35% had no symptoms (they said 'no' to the questions: 'do you have cough, phlegm,