

Editor's Briefing

The NHS is likely to change substantially in the next few years. Much of the recent debate has focused on the unhelpful divide between primary and secondary care and the benefits that closer working between hospital specialists and community generalists may bring. To contribute to this important discussion we asked six leaders of the medical and nursing professions to give us their views about how primary and specialist care may work together in future in the light of the Future Forum report, and their responses make extremely interesting, and generally encouraging, reading. I believe that I detect a feeling in many quarters that this is a once in a lifetime opportunity to redesign the service in a way that may just create an NHS for the 21st century.

I hope that this month's collection of papers on prescribing and the accompanying editorial by Rupert Payne will generate at least as much debate as our recent publications on acupuncture. Together, they are a reminder that prescribing allopathic medicines is fraught with difficulties and can be a source of serious adverse effects and unnecessary expenditure, as well as great therapeutic benefits. Writing and handing over a prescription remains the stereotypical, symbolic final act of the consultation, although not writing one is often more difficult. Patient safety is at the core of many of these papers, such as Mugunthan and colleagues' systematic review of interventions to decrease benzodiazepine prescribing in older people from Australia, and studies on the appropriate use of antibiotics in conjunctivitis by Jefferis and co-workers from Oxford, and the employment of the delayed prescribing strategy in respiratory infections by Peters and colleagues at Manchester. Antidepressant prescribing by GPs has always been controversial (too much? too little?), and Lockhart and Guthrie from Dundee provide new data on trends in antidepressant prescribing in primary care in Scotland between 1995–2007 that shows over 13.4% of the population received a prescription for an antidepressant and that both drug dosages and duration of treatment had increased. They identify the need to understand more about the use of antidepressants for conditions other than depression and to obtain more evidence about the benefits of long-term antidepressant treatment in primary care.

A not dissimilar proportion of some western populations receive prescriptions for antihypertensive drugs, and the main parameter involved in starting treatment,

and changing drugs and dosages is the measurement of the patient's blood pressure with some sort of sphygmomanometer. This is not as straightforward as it may seem. A'Court and colleagues found that, in their survey of 83 practices in Oxfordshire, 14% of sphygmomanometers did not meet British Hypertension Society standards, and also noted that mercury and digital devices were more likely to meet the standard than aneroid machines. Exactly how and when to take the blood pressure in primary care is also problematic, and a group from Nijmegen, Netherlands provide interesting data on the value of asking the patient to rest for 30 minutes during taking the blood pressure to reduce the 'white coat effect' that may lead to inappropriate changes in dosage of drugs.

Back to the future, and the need to assure the quality and scale of the primary care workforce. Helen Lester's Generation Y article, celebrating the creation of a national group, the National Primary Care Society, of medical students promoting primary care as a career choice is also a reminder of the present and future recruitment problems we face, not only in the UK but around the globe. Specialist career tracks are much more popular and primary care is still widely seen as the 'failed consultants' graveyard'. It's disappointing, but not altogether surprising, that the expansion of high quality research in primary care in the university departments has not been paralleled by more effective role-modelling for students on GP attachments and electives. Research success, not teaching excellence, remains the currency of higher education achievement. However, just as the continuing shift of chronic disease care from hospitals to the community has implications for a shift of clinical resources, so the need to train and sustain an adequate primary care workforce has similar resource implications. This month's *Deep End* article reminds us that the Inverse Care Law is still alive and kicking, and that we still don't have enough good primary care services where they are most needed. Making sure that primary care is properly resourced needs to be the focus of a concerted effort to ensure that the new NHS structures and funding mechanisms deliver what is required for a safe future.

Roger Jones
Editor

DOI: 10.3399/bjgp11X593721

© British Journal of General Practice 2011; 61: 537–592.

EDITOR

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2010 impact factor: 2.070

EDITORIAL OFFICE

1 Bow Churchyard, London, EC4M 9DQ

(Tel: 020 3188 7400, Fax: 020 3188 7401).

E-mail: journal@rcgp.org.uk

<http://www.rcgp.org.uk/bjgp>

PUBLISHED BY

The Royal College of General Practitioners,

1 Bow Churchyard, London, EC4M 9DQ.

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

PRINTED IN GREAT BRITAIN BY

HPM Limited, Prime House, Park 2000,
Heighington Lane Business Park, Newton Aycliffe,
Co. Durham DL5 6AR.

Printed on
Carbon Balanced
paper



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www.carbonbalancedpaper.com
CBP0004840504111835