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From patient advocate to gatekeeper: understanding the effects of the NHS reforms

I read Clare Gerada's article in the *BJGP* November issue¹ with some surprise. I had to read to her last paragraph to find areas of agreement with her. I do believe that continuity, accessibility, caring, and the coordination of this matter to patients.

I do not believe the current NHS achieves this well. There are many breaks in continuity throughout the system: within GP surgeries; between GPs and other primary healthcare team members; between GPs and secondary care services; and between health and social care. Access to care is reasonable, but it could be better. Coordination of care could be better at all levels across the NHS. Why are patients sent home from hospital wondering when their outpatient appointment or follow-up test is booked for? Why are they seeing GPs in the vain hope that we will have any better information than they have? Why are they spending time and running up costs, in the wrong part of the system, at the wrong time, for the wrong reason? Why do we expect our fellow citizens to pay taxes for us to indulge such inefficiency? The current UK NHS is a moderately successful health service, but it is in need of improvement. The NHS has been described by Nigel Lawson as, 'the closest thing the English have to a religion.' Rabbi Julia Neuberger commented that she thought its priests had lost faith in their religion.² Practically the NHS needs to be justified by its works, not by faith.

As doctors we need to own the fact that care costs.³ Fragmentation is inefficient, and wastes time and money.⁴ Every decision we make is both clinical and financial. Every statement we make about the worth or value of any treatment is, in part, a financial evaluation. Every decision we make incurs a cost that the NHS is paying. Every pound can only be spent once, so every decision to do one thing is by default simultaneously a decision not to do another. To a large extent NHS doctors have been insulated from the financial consequences of their actions, and

the NHS as a whole has borne them. As Tudor Hart describes, 'at one stage no one in the NHS had much or any idea about how much anything cost'.⁵ In the modern era we cannot get away with such laxity, and indeed in secondary care the accuracy of the coding for payment by results is improving meaning that we now have a far clearer idea about what they are doing, and the levels of comorbidity they are dealing with. Perhaps such techniques need to be extended to primary care so that we get more finely grained information about what and how much we actually do, and then we can stop regretting how much primary care works goes unmeasured, unappreciated, and unpaid.

In other industries workers at a similar level of seniority to GPs would be expected to be accountable for the simultaneous flows of activity and money. Commissioning challenges us to do this for the NHS. It is not a challenge we will all like, but I think it is one we cannot honourably decline.

As I see it, commissioning is the chance our generation of doctors will have to make the NHS navigable.⁶ It is not about either 'gatekeeping' or 'advocacy'. It is not about anything American at all. It is about making the NHS in England work better for its patients.

Far from commissioning heralding the end of the NHS, I see it as the opportunity we have to get the NHS right for the generation to come.

Peter Davies,

*FRCGP, GP, Keighley Road Surgery
Illingworth, Halifax, HX2 9LL; Member,
Calderdale Clinical Commissioning Group.
E-mail: md014j1265@blueyonder.co.uk*

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DOI: 10.3399/bjgp12X616247

In her editorial the Chair of the Royal College of General Practitioners describes the role of GPs as gatekeepers in a negative light.¹ She asserts that this role has arisen in the past 20 years as a result of GPs being encouraged to take financial, as well as clinical, responsibility for their patients. In fact the role of the GP as a gatekeeper has been recognised for at least the past 100 years.² There should be nothing demeaning about GPs having a gatekeeper role — it has been associated with the cost-effective delivery of healthcare services the world over.³

The role of advocate, that she proposes, has legal rather than medical roots. The advocate's only duty is to their client. It presupposes the separate and distinct role of a judge who is responsible for final arbitration. Such separation of advocacy from decision-making is a luxury that does not exist in medicine. In seeking to disengage GPs from the financial concerns of providing health care Dr Gerada is not helping us face reality. It may help us to see financial resources as we do any other finite resource, for example, a blood bank or a doctor's time. Clinical triage principles would direct a doctor to use the blood supplies on those patients in whom it would gain the greatest benefit and not those for whom its use would be marginal or futile. Similarly, a doctor does not decide how to allocate their time simply on the basis of one patient's need but has to spend it with regard to all their patients' needs. In both these cases the doctor does not behave as an advocate for an individual patient but as a steward (a gatekeeper even) of a finite resource who seeks to maximise its effectiveness. It is also important to be clear that the GP would be at fault for closing the gate unnecessarily as well as for opening it irresponsibly. Therein lies the complexity and value of general practice.

John Matthews,

*GP, Park Road Medical Practice, Wallsend,
NE28 7LP; Chair, CareFirst Pathfinder Care*

Commissioning Group, North Tyneside.
E-mail: John.matthews@nhs.net

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DOI: 10.3399/bjgp12X616256

Screening for sickle cell and thalassaemia in primary care: a cost-effectiveness study

Better schemes for providing screening for sickle cell and sickle diseases are to be commended. However, I am concerned that the article by Bryan *et al*¹ is based too heavily upon a cultural paradigm that is white, Anglo-Saxon, agnostic, and pro-choice. This is revealed by the early statement implying that screening later than 10 weeks will be 'too late to make reproductive choices'.

In many Mediterranean and Asian cultures, the first and most important reproductive choice is to get married, and this very often happens a long time before conception. The intent thereafter is to have children, not whether to do so. Screening after that point can generally be regarded as too late within the framework of this article, in which the flow chart and commentary seem to be looking at screening for, and probable termination of, affected pregnancies.

A greater concern for many 'traditionally minded' cultures, in which the concept of termination is not happily entertained, would perhaps be to identify support available to the parents and future children. An increased rate of pregnancy loss, following on from earlier antenatal screening and consequent chorionic villus sampling, may be seen in such situations as counterproductive.

Later diagnosis would be less risky to the child (and less costly) and still allow ample time for preparation for child care, that may involve technologies such as infant bone marrow transplantation to minimise ongoing childhood and adult illness.

The first step must surely be to decide whether the screening is to eradicate babies

with these haemoglobinopathies or to provide support to the future parents of affected children.

An even better screening programme may be offered before marriage, thus truly allowing the reproductive choice suggested by this article! This approach has been taken in some Asian communities in High Wycombe, and perhaps elsewhere.

James Erskine,

MRCGP, MTropPaeds, c/o 141 Dialstone Lane, Stockport, SK7 5BG.

E-mail: jamieerskine@doctors.org.uk

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DOI: 10.3399/bjgp12X616265

Olympic absurdities

My column on the promotion of exercise in the shadow of the Olympics has provoked an upsurge of moral indignation and a flurry of references from an international group of elite specialists and academics.^{1,2} Their response suggests a remoteness from the realities of primary health care, indeed from the real world. I do not claim the authority of scientific evidence or that of prestigious medical institutions, but from the perspective of a jobbing GP point out three self-evidently absurd propositions in the arguments of the exercise zealots.

1. 'Inactivity is a major cause of ill-health'. Over the 30 years in which I have been a GP, the most dramatic change in the health of my patients has been the increase in life-expectancy in old age, most spectacularly confirmed by the growing ranks of centenarians. This increase in longevity has taken place in a population in which only a tiny minority engage in any form of exercise (this is, of course, particularly true of women, who make up the greater proportion of this thriving elderly cohort).
2. 'At least 30 minutes a day of at least moderate intensity activity on five or more days a week is necessary to achieve and maintain good health'. I know club runners and committed footballers who fall short of the exercise standard now being promoted by the Department of Health and endorsed by the Chief Medical Officer. Indeed, a brief

survey of friends, relations, and colleagues reveals nobody who meets it. I do recall a patient with obsessive compulsive disorder and anorexia who met this target, but he was quite ill.

3. 'A brief intervention by a GP can transform a couch potato into an athlete'. A belief in the magical powers of GPs to change established patterns of behaviour (including alcohol consumption as well as inactivity) in the course of a routine consultation (in 3–5 minutes in a popular Australian model) has become widely established in the world of health promotion. But it could not possibly be true that a chat with a doctor could achieve such transformations — and solve, at a stroke, major social problems such as those associated with alcohol. This faith in the power of brief interventions reveals wishful thinking and professional hubris on a cosmic scale.

I am grateful to my GP colleague Rachel Pryke for drawing my attention to *Let's get moving: a new physical activity care pathway* for the NHS.³ It is true that this 86-page document provides numerous assertions like that of our academic trio that 'the evidence is incontrovertible', but no actual evidence, for which the reader is referred to its 43 references. 'Skimming through' these — time is tight and like Pryke I have my QOF targets to consider, especially as these are now being monitored by the exercise police — I find studies flawed by small scale, short duration, using diverse measures of exercise, and unreliable 'self-reporting', all showing modest effects, even after moving the outcome goal posts to guarantee 'success'. *Let's get moving* is permeated with the jargon and dogma of 'motivational interviewing', reflecting the baleful influence of behavioural psychology in medical practice.^{4,5}

Mike Fitzpatrick,

GP, Barton House Health Centre, London, N16 9JT. E-mail: fitz@easynet.co.uk

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DOI: 10.3399/bjgp12X616274