parallel approaches may be necessary and may already be used by GPs in clinical practice. In one approach the GP could ask in a first step if chest pain is caused by myocardial ischaemia and, if the answer is yes, decide on a second step if the situation should be classified as 'acute' or 'stable'. In another approach GPs may ask in every patient with chest pain if there are any red flags indicative for ACS or other conditions requiring urgent admission to hospital. While the MHS aims to support the first approach it does not substitute the second.

Lastly, Djasmo *et al* state that our study does not prove that the MHS performs better than GPs' own judgment based on common practice. We agree that such a comparison would be an important step in the evaluation of the MHS. Even more interesting would be an impact study investigating the effect of using the MHS on outcomes relevant to patients, like mortality. However, the primary aim of our study was to test the robustness of the MHS. We are currently working on an analysis comparing different diagnostic strategies based on the MHS, GPs' assessments, and combinations of both. Since this will be a secondary analysis and since the study was not powered to answer these questions, results will be explanatory. A major concern in future studies will be the sample size. Let us assume that the sensitivity of GPs' assessments would be 85% and that an increase in sensitivity of 5% would be judged as clinically relevant. Based on these assumptions, and the prevalence of CHD in primary care, a sample size of about 6000 patients would be necessary to compare these two diagnostic tests in an adequately powered study using a paired design.[7] Necessary sample sizes for impact studies using outcomes relevant to patients may even be higher. We are not sure if these studies will ever be conducted and assume that recommendations must be based on the limited evidence we have so far.

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Scent of a patient: an underestimated role in clinical practice?

Martina Kelly describes well the ways in which doctors use their sense of smell, including in recognising infection.[1] As well as the infections she describes, I would suggest that from my experience there can be a distinct smell in a patient with some upper and lower respiratory tract infections. When my son was 2-years-old he developed rapid onset of fever, earache, and he smelt distinctly 'bacterially infected'. It was the latter that made me seek medical attention the same evening. He was prescribed amoxicillin and within 12 hours was afebrile, in less pain, and no longer smelt as if he was rotting; he went to nursery and I went to work. I had a clear conscience believing that he did not have a viral infection that he may spread to his peers at nursery.

Perhaps related, I know that taste comes into my decision making to use antibiotics. If a patient describes their sputum or nasal discharge as tasting foul I am more likely to resort to prescribing antibiotics. There will sometimes be an associated odour in such cases.

In this age of guidelines rightly helping us to limit our use of antibiotics, I wonder if smell would be a helpful sign to contribute to decision making. However, I suspect it will never end up in the guidelines due to a lack of randomised controlled trials to provide the evidence required.

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Primary care of children: the unique role of GPs

The editorial on child health in the July issue brings up several points that probably need expanding[1] as it is hugely important to the whole essence of family medicine and its future.

- How many general practice vocational training schemes do not offer paediatrics as a core element of training and how many doctors in training now do a paediatric exam to show competency?
- The out-of-hours services are staffed by GPs but many ill children never get past the triage system and, anecdotally, parents want more than telephone advice and so vote with their feet and turn up in A&E. The most deprived households are likely to be car-free and as such unable to get to remote out-of-hours bases, but do not fit visiting criteria set by the out-of-hours companies. How can these conundrums be solved?
- Pregnant women in our area are directed away from seeing their GP; again anecdotally many women seem not to be aware of folic acid or vitamin D advice prior to their pregnancy. We need to address this in contraceptive reviews.
- There are now waiting lists for paediatric outpatients that were rare in the past

despite the number referred remaining very low. The clinics seem to spend a lot of time reviewing children who should be in primary care (stable asthma for example). Here I hope commissioning can make changes.

- The breakdown in health visiting services, the removal of paediatric checks (after 6 weeks) from general practice all seem to have happened without any local decision making. Were our representatives involved in these changes?
- The model for best paediatric care in busy urban areas may be different from those of us in small towns 25 miles away from hospitals. But unless we put our own house in order and provide highly-skilled, prompt, comprehensive primary paediatric care, then it will be another nail in the coffin of 'general practice' if we lose paediatric care as part of our core role.

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Burnout and empathy in primary care

Thank you for your editorial on 'Burnout and empathy in primary care'.[1] These are crucial, but often neglected, factors in our day-to-day lives as GPs. However, I was surprised that there was no mention of resilience. There is a large body of literature that explores this as a protective characteristic when things get tough. One of the key underlying personal attributes that promotes resilience is a personal faith.[2] Many faiths also emphasise the need for compassion, and teach that compassion can be renewed through personal, spiritual activity. It seems to me that the potentially disparate characteristics of burnout and empathy can be linked through the medium of faith/spirituality. This is something that we are encouraged to address with patients,[3] is it about time that we encouraged its exploration for doctors?

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Communication in the 21st century

As a GPST3 I often visit housebound patients who are unable to come to the surgery. Recently I received a request to visit a 40-year-old woman with a complex history of surgery for diverticular disease in 2010, including a Hartmann's procedure.

My consultation was on an unrelated matter, but during my assessment I asked whether her stoma was functioning well and if there were any plans for reversal, because it seemed from the notes to have been intended as a temporary measure. She was vague about any planned follow-up but said she would be keen to have the reversal. Throughout the consultation I had tried not to be distracted by the Facebook page given pride of place beside the sofa.

When I returned to the surgery it transpired that she had not attended the stoma clinic in 2010 and had then been discharged from follow-up. I arranged for her to be re-entered into the system and phoned her to keep her up to date with developments.

Sitting at home later that evening I couldn't help but ponder the situation. Although my patient was evidently enthusiastic as soon as I brought up the topic of stoma reversal, she hadn't picked up the phone to the surgeons or her GP in 2 years ... if only she could have found us on Facebook!

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Do English patients want continuity of care, and do they receive it?

Aboulghate and colleagues, in their analysis of GP Patient Survey data, conclude that most people value continuity but that practices need to flexibly balance it against speed of access.[1] Asking patients whether they prefer to see a particular GP invites responses that cannot reflect the complexity of their real decision-making.

We have previously reported a discrete choice experiment study of preferences for access to GPs that showed continuity to be a preference that is context-dependent and of variable importance.[2] Patients balance continuity of care against convenience of appointment time and speed of access, according to the reason for their consultation. Those with a long-standing illness value seeing the GP of their choice seven times as much as rapid access, while for those consulting with a child, rapid access is important. Overall, the extra time that patients in this study were willing to wait to see the doctor of their choice was less than 1 day.

Patients weigh up continuity of care as one of several attributes of the health care they require on a given occasion. The access we provide should reflect those values and its quality measured in more sophisticated ways.

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Confirming death in general practice

In 2008 the Academy of Medical Royal Colleges published a code of practice for