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). We regret that we cannot notify authors regarding publication. Letters not published in the Journal will be posted online on our Discussion Forum. For instructions please visit: <http://www.rcgp.org.uk/bjgp-discuss>

Editor's choice

A GP's notes

A letter to GPs ...

I recently had reason to ask my local doctors' practice if I could see my notes — not just the electronic version, but the handwritten too. When I received them, I sat down with my little brown packages and studied them for an hour or two.

Although I was looking for some specific facts, what my general practice notes taught me most is that a detached, respectful response to patients is just what is needed. I confess I expected to find some judgment, criticism, or callousness among the many notes and letters over my 64 years. There was no mention of my broken back being due to horse-riding-while-drunk, or my one foray into illicit drug taking ending up disastrously. Instead I found a comprehensive summary of ailments and breakages, with not a single subjective remark among them. I felt enormously relieved and grateful to a profession that can be detached enough to care just for the body at times, regardless of how much its owner has contributed to its distress, and I felt I wanted to thank you all.

There was one exception to the rule, a long time ago — a verbal telling off by a GP, not something written in the notes. However understandable and human, the power of those comments remained for a long time. Presumably nowadays doctors may take those feelings to clinical supervision or a Balint group? But that was all, in 64 years of medical attention, a pretty good record.

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A new approach to patients with lower urinary tract symptoms (LUTS)

Blanker and colleagues from the Dutch College of General Practitioners Working committee on LUTS write eloquently on

the multifactorial nature of lower urinary tract symptoms in patients presenting in primary care.¹ However, as members of the Guideline Development Group (GDG) for the NICE LUTS in men clinical guideline,² published in 2010, we are perplexed at the criticisms made within this editorial.

The authors selectively quote our guideline and conclude that we 'chose to act as lemmings heading for only one direction: the prostate'. The sentence quoted in the editorial 'In men, the most common cause is benign prostate enlargement ... which obstructs the bladder outlet' is taken wholly out of context. In the guideline document it sits within a paragraph that clearly describes the multiple possible causes of LUTS.

Interestingly, NICE initially commissioned two guidelines, one for benign prostatic hyperplasia and a second for LUTS. At a very early stage however, they recognised that a single LUTS guideline was more appropriate. This reflected a desire to move away from the concept of 'prostatism' towards an open-minded and holistic approach to the possible causes of symptoms in any given patient, ranging from factors such as excessive fluid intake, through heart failure and diabetes, to overactive bladder, and benign prostatic enlargement. The paper quoted in the editorial³ describing the conclusions of an expert panel, which the authors of the editorial felt ran contrary to our approach, had as first author Professor Chris Chapple, the chairman of our GDG, and was published in 2008, during the NICE guideline's consultation period.

The authors suggestions of a scheme for managing LUTS in general practice is difficult to disagree with: a holistic history including patient's concerns, a physical examination including a digital rectal examination, completion by the patient of a frequency volume chart, followed by medical treatment if required, and consideration of surgery if unsuccessful. However, this is the exact pathway suggested by our guideline. The use of the frequency volume chart, a useful and underused diagnostic tool, was preferred to the International Prostate Symptom Score again to move away from the assumption of benign prostatic enlargement as the cause of all LUTS.

We would agree with much of the sentiment expressed in this editorial, but would wish to defend the NICE guideline as really being little different in its message

to primary care. The causes of LUTS are many and varied, with the general practice perfectly placed to make a holistic assessment and initiate initial management, whether through lifestyle measures or medical therapy.

It would be a great pity if doctors chose to ignore the NICE guideline as a result of a false impression given by this editorial and we hope that this letter clarifies the position of the GDG and the intention of the guideline to improve the management of men with LUTS, whatever the cause of their condition.

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Integration of care

My brief experience as a GP clinical commissioner, tells me that we have no choice but to develop closer integration across primary care, secondary care, and social care.¹ The dichotomy between primary care and secondary care has become unhealthy, and most consultants I come across are only too happy to work at joined-up solutions; the nonsensical attempts to push care costs between cash-strapped primary care commissioners and even more cash-

strapped councils has to be changed if we still want to have our bins emptied, as well as care for frail older people.

The challenge for GP partners, as the power brokers in this, is to take action and make their practices ready now for integrated care; waiting for the next contract to sort it out will not make us fit for purpose quickly enough.

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Health inequalities in primary care: time to face justice

I read Dr Moscrop's review article regarding health inequalities in primary care¹ with interest. It is an excellent article that clearly distinguishes differences between inequities and inequalities. However, although the article attempts to raise awareness of health inequality to GPs in the wake of the Marmot report of 2010,² it did not highlight the 2-year update published by the UCL Institute of Health Equity in February 2012 which found that health inequalities had widened in most areas of England.³

The Equality Trust has been set up by authors of *The Spirit Level*⁴ to 'gain the widest public and political understanding of the harm caused by inequality'. The striking messages are that members of more equal societies tend to live longer, have less mental health illness, less illegal drug use, less obesity, and higher levels of trust, with lower rates of homicide, and childhood violence.⁵

People are not oblivious to rising inequality — a *Harris/Financial Times* poll in July 2007 found that 78% of responders felt that the gap between rich and poor was getting larger in Britain.⁶ I feel the challenge is to engage people to tackle the issues — my suggestion is that by ending the article with 'GPs (and GP leaders) surely have an obligation to take on ...' is vague, political rhetoric, and an abstract idea for most GPs.

In Scotland, work assessing ways to reduce inequalities includes the asset-based

approach, which combining social and health care, aims to improve the sense of control a person has over their life by empowering individuals and communities; data are being gathered that may provide evidence for the effectiveness of this approach in the longer term.⁷

I believe to narrow the unjust gap of health inequities the solution lies with the whole of society. Initially raising awareness of health inequality issues is important, this has partly been done by previous national press coverage. With greater public awareness it is likely that developing and implementing government policies to tackle underlying socioeconomic problems would stay a priority: this fundamentally needs to be addressed to solve this problem.

It has been written that 'Many of the policies and strategies designed to reduce inequalities appear to be beyond the scope of individual practitioners'.⁸ I suggest that individual GPs can tackle health inequalities by continuing to provide accurate tailored health promotion messages, signposting patients to local community groups and other relevant agencies (such as Citizens Advice Bureau). A job that I believe is done extremely well by the majority of dedicated GPs.

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Outside the Box: why are Cochrane reviews so boring?

Trish Greenhalgh asks why Cochrane reviews are so boring.¹ Strange that she should ask such a question on this particular platform. Many colleagues ask me the same question about the *BJGP* (identified as I am as the local RCGP stooge because of my varied faculty activities during the course of my career). My answer in both contexts is the same: of course they are boring to practitioners because the job of practitioners is (no surprises) to practice. Both Cochrane reviews and the research articles appearing in the *BJGP*, nevertheless, are essential to the progress of practical medicine. We turn to them when we need them.

To answer another question, I have read Cochrane reviews. Let me give the most recent occasion because the narrative illuminates the synergy between trial evidence and complex decisions. Faced with high rates of referral and surgery for carpal tunnel syndrome, our commissioning consortium sought to explore the alternatives. Many issues had to be taken into consideration: the influence of local expert opinion, secondary-care behaviour in the market, GPs' knowledge of the condition, whether GPs possess the skills for injection and last, but not least, whether splints and injections are effective and safe. My interpretation of the Cochrane reviews on the subject was that the evidence for the effectiveness of non-surgical interventions is weak. But they are safe. So what to do? In this complex situation, the decision to offer non-surgical intervention first line (with safety provisos for those with advanced disease) is sensible. Had the evidence been that non-surgical interventions only delayed surgery or were useless, such a decision would not have been sensible. The evidence was only one part, but a vital one, in the decision.

I do not find Greenhalgh's suggestion of a database of opinions and ideas at all 'outrageous' or even radical. It already exists, it is called the World Wide Web. You can use your favourite search engine to find opinions