their local cottage-hospital rather than many miles distant from friends and family in a big sterile impersonal clinical setting.

You quote Nye's 'efficient if cold altruism'. While we need to question the efficiency of the organisation of larger institutions and distances, we also need to take a moment to consider their 'altruism'. The 'big hospital' is no longer altruistic in its management style or operation: it works for money from the commissioners of care, and often is seen as being sly in its pursuit of profit. A number of the staff remain altruistic, enthusiastic, and dedicated, but this attitude does not fit with management styles, and is being actively driven out of clinical staff, with barriers to flexibility and altruism and rewards for the opposite throughout juniors' careers. We can already see the effects; no longer looking at what is possible, but at what seems to benefit the individual, in terms of career progress.

We need a shift in managerial attitude away from the merely financially measurable, to a holistic approach to all the functions of the hospital. We need a pervasive change in attitude in the community, to rediscover the values of altruism, mutual support, and community pride. Many may consider these too close to religious aims or virtues, but is that wrong?

Real achievement can be made in the face of adversity outside huge institutions. If people will persist in getting ill and having accidents in our rural areas, it is prompt access to local services that is needed, along with the ability to tolerate difficult conditions, stabilise patients, and fix those who then do not need to make long, expensive journeys to big hospitals, rather than the ridiculous campaign for a big, efficient hospital right next door to every patient.

So, yes, I treat wet, muddy patients on occasion, and manage them in the expectation they will have a cold shower back at the camp-site, but also have to pick out those where I believe this will not do, and instruct them to get someone to drop them off at a 'big hospital' on the way home some hours later, or even commit one of our rare precious ambulances to do the job.

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REFERENCE

1. Jones R. Editor's briefing. *Br J Gen Pract* 2012; **62**(602): 451.

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Health inequalities in primary care

I was very pleased to read Chris Weatherburn's reply and to feel that my article may have prompted consideration of some important issues. However, the thought that I may be guilty of 'vague political rhetoric' and peddling abstract ideals prompts me to reply. Additionally, and less egotistically, I feel compelled to counter the implication that we, as GPs, are already doing all we can to tackle health inequities.¹

Social injustices will not get resolved in the consulting room. However, as I tried to point out, injustices can be exacerbated by our failure to acknowledge social determinants of our patients' health and behaviour. Or, as Dr Weatherburn more positively suggests, injustices may be ameliorated by efforts to empathise and respond to our patients' needs. But we can do more than that. Outside the clinic, the RCGP can advocate politically, commissioners can maintain this issue on their agenda, and researchers can provide evidence for decision-makers. The rest of us would do well to consider our own values and priorities, for, to a considerable degree, tackling this issue will demand that we are honest about whether, or to what extent, we are prepared to put social justice before self-interest.

Events this year have not been encouraging.

In March, Julian Tudor Hart had to remind us that progressive taxation was a fairer way of funding the health service than means-tested patient charges (co-payments).²

In May, Alan Milburn highlighted the 'palpable unfairness' limiting access to careers in medicine for people from poor backgrounds. 'Medicine has made far too little progress and shown far too little interest in the issue of fair access,' he said, warning of a society of 'entrenched disadvantage at the bottom'.³

In June, the BMA's strike action prompted *The Daily Telegraph* to cynically quote back to us the words of RCGP President Iona Heath: 'Dr Heath has written [that] people motivated by "economic self-interest" are "indifferent to the fate of others". I wonder whether she will be going on strike...'⁴

As members of a profession committed to improving people's wellbeing I feel certain that we are capable of making more positive contributions toward resolving health and wealth inequities in the future. My article was intended to prompt discussion rather than to claim to define solutions. Nonetheless,

it is apparent to me that while the problem of wealth and health inequity worsens, any amount of complacency is not an answer.

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REFERENCES

1. Weatherburn C. Health inequalities in primary care: time to face justice. [Letter]. *Br J Gen Pract* 2012; **62**(603): 517.
2. Hart JT. How to afford a just health care system. *Br J Gen Pract* 2012; **62**(596): 123–124.
3. Malik S, Wintour P. Medical profession must open doors to poor students, says Alan Milburn. *The Guardian* 2012; **29 May**: <http://www.guardian.co.uk/society/2012/may/29/socialmobility-medicine> [accessed 5 Nov 2012].
4. Palmer A. A doctors' strike puts the ethos of the NHS at risk. *The Telegraph* 2012; **6 Jun**: <http://www.telegraph.co.uk/health/healthnews/9307105/A-doctors-strike-puts-the-ethos-of-the-NHS-at-risk.html> [accessed 5 Nov 2012].

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Possible increased potency of current levothyroxine

Last year one brand of generic thyroxine marketed by Teva was withdrawn by the MHRA. This followed reports of concerns about its effectiveness, including those highlighted by the Vision users group. Since then we have seen an increase in patients with abnormally high T4 levels and suppressed TSH levels in our practice.

An audit comparing thyroid results last year when Teva thyroxine was available and the present time shows a significant rise in T4 levels in some patients who have remained on the same dose of thyroxine throughout.

There may be several reasons for this, including increased potency of current generic thyroxine, changes in concordance, changes in drug interactions, and changes in laboratory testing.

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Hypertension

With the latest update in NICE hypertension guidelines¹ and health and safety concerns with the use of mercury,^{2,3} electronic sphygmomanometers are now very widespread for the detection, diagnosis and monitoring of raised blood pressure. At our recent annual recalibration check, seven electronic sphygmomanometers were checked in The Project Surgery against a standard mercury column. Five were found to be within 'acceptable' tolerance of ± 5 mmHg of true at 100 and 200 mmHg, and two were found to be unacceptably inaccurate, one at 8% inaccurate and one 13% inaccurate and were replaced.

Given that therapeutic choices are made on very small changes on blood pressure reading, and we are invited by NICE to use unmaintained home blood pressure monitoring in diagnosis, even small systemic errors in manometer calibration can have a huge impact on individual patient care.

The only universally accurate manometer one can use to measure blood pressure is a mercury column. Until such time as gravity changes a vertical column of 100 mm of mercury will always be 100 mmHg. On our automated machines before their annual check what was said to be 100 mmHg could have been anything from 92 to 113 mmHg. How can I advise patients when the basic data is so poor? Even the so-called 'accurate' machines can be 5 mmHg out.

I wonder if in our rush to electronic devices we have sacrificed accuracy in favour of convenience. If one adds to this issues around monitors usually being supplied with a 'standard' cuff which is too small for the standard UK arm,^{2,3} and automated sphygmomanometers being unsuitable to detect pre-eclampsia or use in atrial fibrillation,³ is it now time for a rethink our basic surgery equipment? Is the need for a mercury spillage kit too high a price to pay for correct data?

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REFERENCES

1. National Institute of Clinical Excellence. *Hypertension: clinical management of primary hypertension in adults*. Clinical guideline CG127. London: NICE, 2011.
2. Medicines Device Agency. Blood pressure measurement devices — Mercury and Non-mercury. *Device Bulletin* 2000: MDA DB2000(3).
3. Scientific Committees on Emerging and Newly Identified Health Risks. *Mercury sphygmomanometers in healthcare and the feasibility of alternatives*. SCENIHR, 2009.

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Audit awareness among practices

As a past co-chair of Quality Practice Award I have read many submissions from practices where the criterion requested has been to carry out an audit. I have been continually surprised by the lack of awareness of basic audit methodology demonstrated by these practices aspiring to this gold standard award. This is especially concerning as the ability to carry out a full audit once every 5 years is a requirement for revalidation.

There was a very large range of posters at the recent RCGP conference in Glasgow that were placed into categories. One such category was 'audit'. Being aware of the poor awareness of audit methodology among QPA candidate practices, I decided to do an audit of the posters in the 'audit' category.

Criterion 1. An audit should have clear criteria and standards described.
Standard: 100%

Criterion 2. An audit should have a second data collection to show whether change has been successful or not.
Standard: 100%

Data collection 1 October 2012

There were 18 posters in the 'Audit' category.

Criterion 1. Of the 18 posters, seven (39%) described criteria and standards (this was allowing as a positive result, any attempt to state the aspect of good practice being measured, and a level of achievement towards that aspect even if the words 'criteria' and 'standards' were not used).

Criterion 2. Of the 18 posters, only three

(17%) went as far as providing a second data collection.

Analysis of data collection 1

Most of the posters were surveys and, although describing interesting pieces of work, were not audits. These had been wrongly classified as audits for the conference. Does this indicate a lack of audit awareness among those in the RCGP responsible for the poster display?

Change

There needs to be much more learning about audit methodology and that this needs to be across the entire primary care workforce. We could find audit to be a major issue for revalidation if this is not addressed.

Of course, my audit fails my own test of being an audit as I have not enacted change personally. But I do look forward to the Data Collection 2 in Harrogate next autumn.

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Corrections

The author list was incomplete in the article: Keynejad M *et al*. Medical ethics debate: access to NHS resources. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X654696. The full author list should have read: Ishaac Awatli, Medical Student, King's College London; Guy Bower, Medical student, St George's University of London; Sharenja Jayabaladevan Medical student, St George's University of London; Roxanne Keynejad, Foundation Year 1 Doctor, St Helier Hospital; Vongai Madanire, Medical student, St George's University of London; Alice Michell, Medical student, St George's University of London; Daniel Thompson, Medical Student, King's College London; Mark Yao, Medical Student, King's College London.

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The first publication of the following article was not the latest version: Eborall, *et al*. Influences on the uptake of diabetes screening: a qualitative study in primary care. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X630106. The latest version is now online. We apologise for this error.

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