

## Editor's choice

### Assisted dying

Professor Finlay is absolutely right that GPs' opinions are vitally important in the assisted dying debate, and that it is important for the College to have a view on this issue.<sup>1</sup> Physician-assisted suicide would involve GPs in assessing requests for assisted suicide and would also require GPs to prescribe lethal doses of medication. It would also be highly stressful for GPs, as seen in the Netherlands. It is vital that GPs' views are expressed and taken into account by legislators. It is also vital that any change in the College's position is only made after a ballot of members. This is not a difficult thing to do, and is vital to ensure transparency and openness. Professor Finlay's Viewpoint piece is a timely and welcome contribution to the physician-assisted suicide debate.

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#### REFERENCE

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## Sustainability in primary care

The very mention of 'sustainability' is usually enough to send me screaming from the room, and so I was minded to skip over Tim Ballard's editorial on the subject.<sup>1</sup> I'm glad I chose instead to read what he had to say, as I would otherwise have missed an unusually thoughtful and thought-provoking article.

He points to the role of the GP in providing 'high quality generalist personalised care' and argues persuasively that such an approach is resource efficient. He extends this argument to consider the potential impact of commissioning and the opportunity this provides for avoiding unnecessary duplication of services. However, my experiences to date suggest that the precedents are not

encouraging, and I have observed that most commissioning decisions made in the name of efficiency achieve anything but (unless this is the same type of efficiency that persuades manufacturers to outsource their labour abroad).

The real sustainability challenge for primary care is whether we have the courage to resist the juggernaut that is the healthcare industry and regard health care as a precious resource rather than a consumable. I suggest that every unnecessary prescription, every unnecessary screening service, and every unnecessary referral we provide for our overwhelmingly well patients is a misuse of this resource. I also agree with Ballard that we should resist taking undue responsibility for the consequences of excess consumption; much that passes for health promotion is indeed shutting the stable door after the horse has bolted, as he well describes. Again, precedent suggests that we have a way to go in this regard; how else to explain our unquestioning adoption of much of the QOF, over 50s health checks, and other ill-conceived health promotion initiatives?

Anyway, I had better stop writing now as I can see my surgery car park is filling up with the impressively fuel-efficient cars of those arriving for their health checks. While our practice nurse is seeing them, I should get on with signing the rainforest's worth of repeat prescriptions. Funny, but the pile seems to be getting bigger all the time ...

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#### REFERENCE

1. Ballard T. What sustainability means for primary care: primary care leads to better overall resource use and higher quality outcomes. *Br J Gen Pract* 2013; **53(614)**: 457-458.

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## Carbon footprint of patient journeys

May I add one further aspect to the discussion relating to patients travelling to and from surgeries and its environmental impact<sup>1,2</sup> that I have yet to hear included in any public

debate — and that is the obvious conflict with the 'choice' agenda. We, too, are a practice in a deprived inner-city area with high rates of chronic disease, and yet a significant number of our patients still drive 3, 4, or 5 miles through town to visit the practice. It is not uncommon for patients to ring saying they will be late as they are 'stuck in traffic' or be stressed if the doctor is running late and they have only paid for 30 minutes on the meter. Ironically, they will have driven past or close by to at least some seven or eight surgeries on their way in.

We will all be familiar with the disgruntled patient who does not see why they have to change doctors even if they have moved a considerable distance away. Yet government initiatives have been to promote keeping such patients on the list.<sup>3</sup> The current patient choice agenda seems to pay little heed to such genuine wider concerns as this study demonstrates; and ignoring them does not make them go away.

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3. Department of Health. *Your choice of GP practice: a consultation on how to enable to register with the GP practice of their choice*. London, DoH, 2010.

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## Managing dyspepsia in primary care

It was interesting to note that both authors of the article *Initial management of dyspepsia in primary care* were secondary care physicians.<sup>1</sup> In their otherwise practical approach to managing this common problem, no mention was made of upper gastrointestinal symptoms occasionally being the only early warning of possible ovarian malignancy. Many GPs would now consider arranging a CA125 blood test.

Perhaps it is wrong to generalise too much from this observation, but it does illustrate just how holistic we 'general' practitioners have to be.

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#### REFERENCE

1. Ansari S, Ford AC. Initial management of dyspepsia in primary care: an evidence-based approach. *Br J Gen Pract* 2013; **63(614)**: 498–499.

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## Future proofing primary care

In the September issue of the Journal, Tim Ballard wrote: 'The penny dropped with me at the RCGP Annual Conference in Harrogate last year, that the best way of future proofing the healthcare system in the UK is to invest in the education and skills of GPs and their teams, in short, helping them to deliver high quality generalist personalised care. At the heart of this is the skill to deliver bespoke patient care and manage risk without resorting to over-medicalisation and consequent high resource use.'<sup>1</sup>

In the same issue, in an article on dyspepsia in primary care, two gastroenterologists wrote: 'The initial management of uncomplicated dyspepsia in the community should consist of either non-invasive testing for *Helicobacter pylori*, so-called 'test and treat', with proton pump inhibitor (PPI)-based triple therapy for those testing positive (PPI and two antibiotics) and 4 weeks of PPI for those testing negative, or empirical PPI for all patients.'<sup>2</sup>

The gastroenterologists seem to be teaching us how to cope without an endoscope. Surely, as Ballard's editorial indicated, our scope needs to be wider than this: we have to learn not just about *H. pylori* but also about other causes of abdominal pain, about the low predictive values of tests, about the way symptoms change over time, either improving spontaneously or becoming more clearly defined, and about the power of serial history and examination.

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## Response to 'Repeat prescribing = hassle'

Greenhalgh bemoans the fact that repeat prescribing has become a chore and generated its own bureaucracy.<sup>1</sup> Much of the hassle is self-inflicted.

My hypertension was diagnosed while I was serving in the Army. Once it was brought under control I was reviewed every 6 months and was given a prescription for 6 months supply of medication. On retiring and coming under NHS care, I was still reviewed 6-monthly but was only trusted with a month's supply of medication at a time on the basis of PCT guidelines.

I fully understand that some patients cannot manage 6 months' supply of medication and in my days as an NHS GP I emptied older patients' drug cupboards of hoarded drugs.

My challenge to you is to regard guidelines as what they really are, practice the personalised, patient-centred care, which you all espouse, and trust those of us who can manage their drugs by prescribing reasonable amounts and go back and enjoy coffee, cake, and the conviviality of an informal meeting with your colleagues and make repeat prescribing less of a chore. Are there any good reasons why you should not?

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## Persistent cough in children

Philipson *et al* have provided more evidence on subclinical *Bordetella pertussis* infection.<sup>1</sup> After reading the article one could think that *B. Pertussis* was just another, impossible to distinguish, cause of prolonged coughing, that only a laboratory test will illuminate. I think it needs to be pointed out that whooping cough is a real syndrome, with a largely forgotten, but unique characteristic that makes clinical diagnosis possible, and that we now realise, co-exists with subclinical infection.

I have studied 740 cases of clinically diagnosed whooping cough in the Keyworth Practice since 1977.<sup>2</sup> The characteristic that distinguishes clinical pertussis is not the 'whoop', but the very long intervals (can be hours) without coughing, contrasting with the severe choking paroxysms that occur on average every 2 hours. Patients do not volunteer this information, indeed very few are aware of it until they have thought about it.

It is possible, but I think unlikely, that none of the oral fluid positive patients in Philipson's study had clinically diagnosable pertussis. If the right questions had been asked, the software may have learnt something, and very likely improved on the average clinician.

Pertussis is diagnosable if the characteristic symptoms are known and the right questions asked, or if the clinician hears the sound of a real whooping cough paroxysm and learns the tune, which few have had the opportunity to do, since the cough is inconveniently intermittent.

There is probably more danger from cases missed through lack of diagnostic skill than there is from the unknown number of subclinical cases, which, as opposed to missed cases, are not very important in the transmission of this disease that is still killing babies.

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