route from the West Midlands to Manchester, Leeds and beyond. Sustainability Statement. Appendix E9 — Health Analysis. A report by Temple-ERM for HS2 Ltd. London: Temple-ERM, 2013.

3. Department of Health. *Preventing suicide in England, A cross-government outcomes strategy to save lives*. 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf [accessed 7 Jan 2014].
4. HS2 Ltd. Key Dates. <http://www.hs2.org.uk/about-hs2/key-dates> [accessed 7 Jan 2014].

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Will the age of austerity save the NHS?

I have always been a passionate supporter of the NHS and initially viewed the Nicholson challenge as a threat to the future of the NHS; now though I wonder if it may actually save the NHS.

Among the many good things the last government did for the NHS there were changes that have significantly increased costs without improving quality of service. Agenda for change, the working time directive, consultant contracts and GP opt outs for out of hours all improved quality of life for staff, but have not improved health outcomes for patients. Significantly increasing costs without improving outcomes has also reduced productivity. Innovations in patient services, such as walk in centres, NHS Direct and Darzi centres, again driven more by wants than needs, have improved access without improvements in health outcomes. This has come at a time of previously unimaginable advances in quality of life and life expectancy, with the elderly population in some areas increasing by 30% over the past 10 years. A rapidly increasing elderly population with falling productivity will make current NHS provision unaffordable within a generation.

With the population growing and health cost inflation exceeding GDP growth even pre-2008 levels of funding will soon be insufficient without significant structural reform. While it is tempting to let our children worry about this, the crunch point of affordability is coming and if we don't plan for this, we will soon reach a point where a publicly-funded, universal free healthcare system will be unaffordable. Prior to this, health and social care costs will gradually throttle our economy as demand increases.

Depressing though this is, we have the opportunity to avert disaster. Humans have a natural capacity for innovation, and if we can

embrace this to evolve our health delivery model we can evolve to one that is sustainable for the next few decades. In times of plenty, changes in public services were often based on wants rather than needs. In the next decade, changes will have to be based on patient needs. As long as the patient is at the centre, selection of only those innovations that improve productivity and improve care, can reshape the way we deliver care for our population in the 21st century. Failure to embrace this change will result in a health system like the US, where only the rich have access to health care.

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Reducing inappropriate A&E attendances

Ismail *et al* clearly show that interventions in primary care do not decrease the number of inappropriate attendances at accident and emergency departments (A&E), nor increase patient self-care.¹ In Belgium (Flanders), we observed a large increase in attendance of young children at primary care out-of-hours (PCOOH) services after implementation of a general practice cooperative (GPC).^{2,3} Recently, data from new PCOOH services in colocation with A&E showed nearly identical findings. Patients increasingly use the GPC, while patient fluxes to the A&E remain stable. These observations can be partly explained, because implementing PCOOH services was not meant to improve overall efficiency of the healthcare system, but rather a response to increasing strain on OOH care: lowering numbers of GP equivalents, feminisation of workforce, and decreasing safety during home visits were principal drivers for these changes. From earlier work, we know that patients tend to choose PCOOH services based on their previous experiences and that they like a technical environment.⁴ Modest co-payment does not significantly influence health seeking behaviour.⁵ Patients do not tend to think in 'primary' and 'secondary' care when in [perceived] need for urgent care. To change patient behaviour, we need well-designed, multifaceted interventions envisaging high quality and sustainable health care, not in response to dissatisfied groups of professionals. This means that professionals

and their payers collaborate to establish integrated models of care. In Belgium (Flanders) this would mean structural collaboration of A&E and PCOOH services, and not competition for the majority of the patients. Due to rapidly declining numbers of GPs and medical specialists working in A&E, our professionals seem ready for this. Financial issues of these services need to be tackled as stakes are high for all stakeholders. Raising public awareness about appropriate health services use is of major importance as well.⁶ From the BBC Masterchef series we learn nearly every day that good cooking is possible for everyone. However, we did not observe any instructive series on how to deal with urgent needs within our health system.

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REFERENCES

1. Ismail SA, Gibbons DC, Gnani S. Reducing inappropriate accident and emergency department attendances: a systematic review of primary care service interventions. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X675395.
2. Philips H, Remmen R, Van Royen P, *et al*. What's the effect of the implementation of general practitioner cooperatives on caseload? Prospective intervention study on primary and secondary care. *BMC Health Serv Res* 2010; **10**: 222.
3. Streffer ML, van Bergen J, Philips H, *et al*. *Rapport Huisartsenwachtpost Antwerpen Noord. 2013*. <http://www.ua.ac.be/main.aspx?c=hilde.philips&n=14&ct=onderze> [accessed 7 Jan 2014].
4. Philips H, Mahr D, Remmen R, *et al*. Experience: the most critical factor in choosing after-hours medical care. *Qual Saf Health Care* 2010; **19**(6): e3.
5. Philips H, Remmen R, De Paepe P, *et al*. Use of out-of-hours services: the patient's point of view on co-payment a mixed methods approach. *Acta Clinica Belgica* 2013; **68**(1): 1–8.
6. Philips H, Remmen R, De Paepe P, *et al*. Out of hours care: a profile analysis of patients attending the emergency department and the general practitioner on call. *BMC Fam Pract* 2010; **11**: 88.

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Studying and reducing DNAs to improve access

We originally had a 4-week advance booking

system for appointments which we had for over 10 years but were not performing well on 'access' because of a high number of patients who did not attend (DNA). We often had over 100 DNAs per month so many appointments were being wasted. I noticed that another local practice which permitted advance booking only 2 days ahead scored better in the 'access' survey than our practice. Another local practice was piloting a same day booking system with no appointments booked in advance, from June 2013.

We calculated that we had nearly the correct number of GP and nurse appointments per 1000 patients, per week. The Local Medical Committee had advised 100 appointments per 1000 patients per week. We are an average size practice of 6400 patients.

An audit of the DNAs in April 2013 showed that 80% of DNAs had booked more than 7 days previously, so we changed to a 1-week advance booking system from 1 July 2013 with 50% of appointments bookable in advance and 50% available on the day, for GP appointments but not nurse appointments. The 'same day' appointments were unblocked on the day at 8 am each morning to prevent them being booked online.

A repeat audit of DNAs in October 2013 showed that 75% of patients who DNA had booked more than 3 days ahead so we have just changed to a similar 3-day booking system from Monday 9 December 2013. This has reduced our DNAs and reduced stress within the practice. Other practices in the UK may wish to consider these ideas. I have concluded that a 2–3 day advance booking system is the right one for our practice and will probably be optimal for most practices.

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Predictive validity of selection for entry into postgraduate training in general practice

The recent paper by Patterson *et al*¹ reports the encouraging and considerable predictive validity of MCQ (CPS 'clinical problem solving') and situational judgment test (SJT) selection

tests for performance on the two MRCGP formal examination components.

The MCQ and the SJT correlate with the Applied Knowledge Test (AKT) at 0.85 and 0.69, respectively (range-corrected). From data provided in the paper, together the two selection tests can be seen to predict 74–75% of AKT score variance. The two tests also correlate with the old-style Clinical Skills Assessment (CSA: 0.55, 0.57, respectively, range-corrected). Together they predict 37–38% of CSA Score variance. But the subsequent Selection Centre (SC), then a three station OSCE and correlating with the CSA at 0.41 (range corrected), is reported as only explaining an additional 2% of CSA score variance.

Given that a set of computer-delivered multi-choice tests will cost £100–200 per candidate and that the true cost of a selection centre will be at least £1000, the latter seems to provide relatively very poor value, especially with about 5000 candidates being shortlisted for selection in 2012.² Perhaps the £5 million-plus could be better used in supporting poorly-performing trainees?

Also, those of us who are responsible for devising OSCE assessments would be grateful to learn how one with three stations, single marked, can be devised such that its reliability (Cronbach's α) is 0.87, when considerably longer similar assessments give far lower reliability estimates; for example, MRCGP CSA (13 stations) 0.77,³ and iMRCs Part B (8 station subtests) 0.68–0.72 and (10 station subtests) 0.76–0.78.⁴

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REFERENCES

1. Patterson F, Lievens F, Kerrin M, *et al*. The predictive validity of selection for entry into postgraduate training in general practice: evidence from three longitudinal studies. *Br J Gen Pract* 2013; DOI:10.3399/bjgp13X674413
2. National Recruitment Office. *Summary of the recruitment data by recruitment stage and deanery*. 2012. <http://www.gprecruitment.org.uk/annualreports.html> [accessed 7 Jan 2014].
3. Royal College of General Practitioners. *MRCGP Statistics 2011–12: Annual Report on the AKT and CSA Assessments*. <http://www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/mrcgp-annual-reports/-/media/Files/GP-training-and-exams/Annual%20reports/MRCGP%20Statistics%202011-12%20final%20121212.ashx> [accessed 7 Jan 2014].
4. Intercollegiate Committee for Basic Surgical Examinations. *2012/13 Annual Report*. http://www.intercollegiatemrcs.org.uk/new/pdf/Annual_Report_12_13.pdf [accessed 7 Jan 2014].

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Why study?

In November's *Out of Hours*, Trisha Greenhalgh asked the rhetorical question 'Why study?'.¹ Her reflections were prompted by one of her self-funded, mature students completing his PhD while studying part-time and working as a full-time clinician.

She answered her own question by suggesting academic study resulted in both a public good and a benefit to the individual undertaking study for its own sake. As the student referred to in her article, perhaps I can provide a perspective on the personal benefits of academic study.

After approximately 25 years of non-academic full-time clinical practice, I felt at a crossroads. I wondered what I was going to do with the rest of my life. Clinical practice can be immensely fulfilling but it can also become mind-numbing under the pressure to care for a seemingly unending stream of patients.

Academic study provided an opportunity for me to pause, reflect on, and understand my experience within a larger context than my own practice. I found it immensely satisfying to think about 'big ideas' and academic study provided an opportunity to do so.

A structured programme of academic study produced many side benefits. It increased my self-confidence and self-esteem. My information searching and retrieval skills, improved. My ability to write coherently without resorting to wild hyperbole continues to develop. Even my spelling improved. Academic study changed both my way of thinking and approach to problems. I learned to evaluate how arguments are constructed, consider evidence used to justify assertions, recognise rhetoric, and most importantly I learned to be sceptical and not to accept conclusions at face-value.

Academic study requires considerable investment of time, energy and money. Having the opportunity to observe full-time academics for the past decade made me realise I do not want to be one. For me, the main reason for prolonged academic study was personal fulfilment. So, for the time being I plan to continue my clinical practice and remain a hobbyist researcher. I now realise there are many opportunities to do meaningful research on a shoestring budget or no budget at all. I look forward to many more years having more fun doing this!

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REFERENCE

1. Greenhalgh T. Why study? *Br J Gen Pract* 2013; **63(616)**: 595.

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GPs’ job satisfaction: doctors who chose general practice early or late

In their study on GPs’ job satisfaction Lambert *et al.*¹ describe the feeling of GPs 1–10 years after graduation. The authors conclude that the level of job satisfaction was generally high among both late and early choosers. Most GPs turn to general practice after initially preferring another speciality at the beginning of their career and the majority will have a satisfying career.

To understand the factors behind their choice, we questioned 198 students’ in the Faculty of Toulouse (South-West France) about their reasons for choosing general practice.² The result of our survey was that a GP career was chosen for its diversity and the doctor–patient relationship, with the fact that it is a speciality often held in low esteem being the main obstacle. 37.5% (*n* = 74) had hesitated between general practice and another medical speciality, 66% (*n* = 131) said that general practice was their first choice. Their positive choice in favour of general practice was based on several key factors: the characteristics of the profession, training in a general practice, the quality of education, the conditions of future practice and quality of life. Six profiles were defined: the convinced, with a conscious preference for general practice; the visitors from the north of France, attracted by the southern climate and the characteristics of the profession; the opportunists, particularly interested in doctor–patient relationship; the sedentary students, who have always lived in Toulouse and gave priority to personal relationships; the southerners for whom the choice of town was more important than the choice of speciality, and those who chose the faculty for its quality of its teaching and its reputation.

The conclusion drawn by Lambert *et al* may give the impression that most doctors had chosen general practice as a last resort. In reality, the choice for general practice depends on many factors and knowing the true reasons for this choice can help understand practitioners’ level of job

satisfaction. This is an important factor that should not be overlooked.

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REFERENCES

1. Lambert T, Smith F, Goldacre M. GPs’ job satisfaction: doctors who chose general practice early or late. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X674404.
2. Bismuth M, Rouge-Bugat ME, Poutrain JC, *et al.* *Medecine* 2013; **9**: 136–141.

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Are GP career intentions more prevalent in UCL Primary Health Care iBSc students?

Peile¹ mentions the importance of the role of medical schools in influencing students to consider a career in general practice. Research on the undergraduate determinants on medical students’ career choices and specifically choosing a career in general practice^{2,3} is important because medical schools can now tailor their teaching to overcome the problem of the declining number of GPs. Little research has been done on the career impact of iBSc degrees, and less on iBScs in primary health care (PHC). Traditional pre-clinical iBSc degrees have often influenced students academically, and discouraged them from becoming GPs.^{4,5} The PHC iBSc course is a relatively new course at UCL, and it aims to widen the scope of medical education by developing research, clinical and critical appraisal skills as well as exploring general practice in depth.⁶

We carried out a case-control study of current UCL students, in the form of an online survey. This study was approved by the UCL ethics committee. All PHC graduates from the 2009–2010 to the 2012–2013 cohorts were identified. Each was matched (in terms of iBSc completion) with three students from any other iBSc degrees from UCL.

Questionnaires online were then made available to them for their completion. The response rate was 33 out of 104 (31.73%), 13

(of 15) PHC students expressed a degree of interest in general practice, while only 8 (of 18) non-PHC students expressed interest. This was statistically significant (OR = 8.125, *P* = 0.002). There were no other correlations between GP intention and sex, stage of medical school or ethnicity. This study suggests that the PHC iBSc is associated with a stronger interest in a GP career, and demographic variables in this group did not impact on GP career intention. A potential bias is that the students enrolled on the PHC course may already have developed a strong interest in a GP career prior to their iBSc year which may have influenced our results.

A PHC iBSc course better informs students about general practice, although being better informed alone does not directly translate to a stronger GP career intention.

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REFERENCES

1. Peile E. General practice careers: choices and judgements. *Br J Gen Pract* 2013; **63(616)**: 565–566.
2. Ali B, Jones M. Do medical students want to become GPs? *Br J Gen Pract* 2003; **53(488)**: 41.
3. Henderson E, Berlin A, Fuller J. Attitude of medical students towards general practice and general practitioners. *Br J Gen Pract* 2002; **52(478)**: 359–363.
4. McManus IC, Richards P, Winder BC. Intercalated degrees, learning styles, and career preferences: prospective longitudinal study of UK medical students. *BMJ* 1999; **319(7209)**: 542–546.
5. Jones M, Hutt P, Eastwood S, Singh S. A Best evidence systematic review of the impact of an intercalated BSc on medical student performance and careers. *Best Evidence Medical and Health Professional Education* 2013. <http://www.bemecollaboration.org/Published+Reviews/BSc/> [accessed 6 Jan 2014].
6. Jones M, Lloyd M, Meakin R. An intercalated BSc in primary health care: an outline of a new course. *Med Teach* 2001; **23(1)**: 95–97.

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Text messaging to promote health

Douglas and Free’s qualitative study¹ alongside a randomised controlled trial² show that text messaging offers a valuable way of supporting people trying to give up smoking. Text messages may also have

wider potential in health promotion, including within sexual health.

In September 2013 we carried out a patient and public involvement user group to investigate what female genitourinary medicine clinic attendees thought about texts encouraging regular STI checks, use of long acting reversible contraception (LARC) and HIV testing. These three topics were chosen in response to the 2013 Framework for Sexual Health Improvement, which highlights sexually transmitted infections (STIs), teenage pregnancies and late diagnosis of HIV as major public health problems.³

Consecutive women aged 16–24 years attending the Courtyard Sexual Health Clinic at St George’s NHS Trust, London were invited to complete a confidential, anonymous questionnaire and to express opinions. The response rate was 100% (30/30), and the mean age of participants was 20 years (range 16–24 years).

Text 1: ‘Time for your check-up? Please telephone ...’ 27/30 (90%) thought this reminder a good idea, and 23/30 (77%) said they would book a check-up.

Text 2: ‘Have you thought about trying a contraceptive implant or coil so you don’t have to keep remembering? Ask when you go for your check-up.’ 23/30 (77%) were happy to receive this, and 20/30 (67%) would ask about LARC.

Text 3: ‘Have you thought about HIV testing ... ? Ask when you have your check-up.’ 25/30 (83%) liked this reminder, and 24/30 (80%) would ask about HIV testing at their next check-up.

Comments included: ‘A really good idea and could help a lot of women.’ ‘Very straight and to the point.’ ‘Young girls don’t think about this so it’s good to give them awareness.’ Overall there was a positive response to receiving all three texts, and over two-thirds of responders said they would act on them.

We agree with Douglas and Free¹ that it is important for healthcare professionals to understand patient experiences of a text messaging service. User groups can also be helpful. Text messages are increasingly used for appointment reminders in primary care and could have potential as key health promotion tools in the future.

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REFERENCES

1. Douglas N and Free C. ‘Someone batting in my corner’: experiences of smoking-cessation support via text message. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X674459.
2. Free C, Knight R, Robertson S, *et al.* Smoking cessation support delivered via mobile phone text messaging (txt2stop): a single-blind, randomised trial. *Lancet* 2011; **378 (9785)**: 49–55.
3. Department of Health 2013. *A Framework for Sexual Health Improvement in England*. <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england> [accessed 7 Jan 2014].

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Social media in general practice: a ray of hope or a can of worms?

We read with interest the letter by Lad and McGowan¹ in which they present their views on the future of patient–doctor communication in healthcare. In response to their suggestions, there are four points we would like to address. Firstly, while a paperless NHS is a desirable, and perhaps inevitable, progression, we draw a critical distinction between IT and social media in achieving the ‘iSurgery.’ Indeed, the lack of security in social media is well documented² and has many ethical and legal implications for patient confidentiality and consent, two inalienable aspects of good medical practice.^{3–4}

Moreover, we disagree that the next logical step for IT in medicine is social media: there is little evidence to suggest traditional modes of communication (letters and telephone calls) between GPs and patients are ineffective or disliked by patients. As the old mantra states: ‘If it isn’t broken, why fix it?’ Effecting wide-sweeping change in the current climate of financial strain would be challenging enough without considering the steep learning curve for GPs and practice staff.

Thirdly, while mobile text and email interactions between GPs and patients have reportedly had positive outcomes, can we translate this to social media?^{5–6} Clearly, the former have significantly wider use across all demographics than social media. Furthermore, a move towards social media potentially increases the risk of excluding vast subsets of society who do not use or do not have access to such websites.

Finally, though the traditional paternalistic consultation is increasingly a thing of the past, in promoting telemedicine, there may be a danger of failing to adequately address patient concerns and overlooking key body language cues which would otherwise be apparent in face-to-face communication. The adoption of wide-ranging social media in healthcare would also be vulnerable to device failure and website maintenance, which occur commonly, leading to frequent periods of impaired communication between doctors and patients.

We commend Lad and McGowan in seeking improved patient–doctor communication, and agree that this should be a key area of future innovation and discourse among healthcare professionals. Overall, however, the practical and ethical detriments of social media in the healthcare setting outweigh the benefits outlined by the authors in their letter. We feel, instead, that the current focus in healthcare IT development should remain for the moment with greater harmonisation of disparate patient information networks coupled with continuing development of electronic patient notes and records.

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REFERENCES

1. Lad M and McGowan D. The iSurgery. *Br J Gen Pract* 2013; **63(616)**: 574.
2. Lehavot K, Ben-Zeev D, Neville RE. Ethical considerations and social media: a case of suicidal postings on Facebook. *Journal of Dual Diagnosis* 2012; **8(4)**: 341–346.
3. Bourke J, Wessely S. Confidentiality. *BMJ* 2008; **336**: 888.
4. O’Neill O. Some limits of informed consent. *J Med Ethics* 2003; **29(1)**: 4–7.
5. Neville R, Marsden W, McCowan C, *et al.* Email consultations in general practice. *Inform Prim Care* 2004; **12(4)**: 207–214.
6. Neville RG, Reed C, Boswell B, *et al.* Early experience of the use of short message service (SMS) technology in routine clinical care. *Inform Prim Care* 2008; **16(3)**: 203–211.

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