Asthma care in general practice

Mark Levy is to be congratulated for completing the review of asthma deaths.1 However in the way that they take a narrow specialist perspective, the recommendations seem to have been written by specialist physicians rather than primary care generalists. Specialist asthma clinics would place a burden on both nurses and doctors that will simply break the system. All that is required is familiarity with the latest research evidence and a willingness to try to apply them sensitively to the range of patients, with their range of asthma severity, taking into account those keen to manage themselves in a compliant way and those keen to deny the existence of their condition and anxious to reject all professional advice.

Every time that committed doctors investigate some particular area of practice they need to be reminded that the best primary care overall is provided by generalist doctors, and that any attempt to improve care for patients with particular conditions has to be integrated into general care and not bolted on as a vertical programme; and this is as true in the UK as it is in any developing country.

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The importance of continuity of care

Dr Benett is right that access and continuity are interlinked and we agree that general practice needs investment in capacity.1 However, it is disappointing to see a clinical director of a CCG writing that there is only ‘equivocal evidence on the relationship between continuity and patient outcomes’. It is revealing that he uses Harold Shipman as evidence against continuity of care in a scientific journal.

With the doctor–patient relationship being as strong as it is, some adverse effects are inevitable. The ‘heartsink’ phenomenon is one3 and there are a small number of studies suggesting delayed cancer diagnosis.2 Collusion is a problem in all clinical practice and may be associated with continuity of care in general practice.

However, these adverse findings have all been countered, so that the same Rogers et al article3 also showed that increased trust in the doctor improved cancer detection, and trust in the doctor is itself associated with continuity of general practice care,4 while O’Connor et al showed that a regular provider was associated with significantly improved diabetes care.5 Directors of CCGs should know of the three really big gains in outcomes from continuity of care all of which matter to the whole NHS: increased patient satisfaction, better uptake of evidence-based preventive care, and, as from Canada,6 Norway, the UK, and the US, consistently shows, fewer emergency admissions to hospital. Dr Benett’s CCG is currently paying £1844 for each emergency hospital admission.

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