

All letters are subject to editing and may be shortened. General letters can be sent to [bjgpdisc@rcgp.org.uk](mailto:bjgpdisc@rcgp.org.uk) (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication. For submission instructions visit: [bjgp.org/letters](http://bjgp.org/letters)

## General practice in UK newspapers: the influence of major policy changes

We read with interest the findings of Barry and Greenhalgh indicating the continuing negative portrayal of GPs in UK newspapers.<sup>1</sup> The authors highlight that general practice is seen as a service in crisis, with low morale and high burnout, and that GPs are portrayed as being responsible for the crisis and resulting negative impacts on patient care.

Our previous studies suggested that UK newspaper coverage of general practice became unfavourable following the introduction of the new General Medical Services contract in 2004.<sup>2</sup> Previous recognition of demanding working conditions and relatively poor rewards in general practice transformed into a predominantly negative portrayal, with concerns about unfairly excessive income and poor use of public money. The introduction of the Health and Social Care Bill in 2011<sup>3</sup> continued this trend, with signs of eroding trust in GPs. Public perceptions of how GPs are paid will continue to damage public trust if the drive to meet pay-for-performance targets is perceived as undermining patient-centred care.

Persistent negative media coverage may also hinder GP recruitment and retention. We advise that media stories written by doctors may mitigate this unfavourable trend. We suggest that GPs should actively engage with the media to broaden the debate from costs and capacity alone to quality and equity of care.

Sarah L Alderson,  
*NIHR Academic Clinical Lecturer in Primary Care, Leeds Institute of Health Sciences.*  
Email: [s.l.alderston@leeds.ac.uk](mailto:s.l.alderston@leeds.ac.uk)

Adam Balkham,  
*Psychiatry Core Trainee 1, Birmingham and Solihull Mental Health Trust.*

Robbie Foy,

*Professor of Primary Care, Leeds Institute of Health Sciences.*

### REFERENCES

1. Barry E, Greenhalgh T. General practice in UK newspapers: an empirical analysis of over 400 articles. *Br J Gen Pract* 2019; DOI: <https://doi.org/10.3399/bjgp19X700757>.
2. Tanner F, Foy R, Harrison W. 'Wads up, doc' – trends in British newspapers' reporting of general practitioners' pay. *Prim Health Care Res Dev* 2010; **11(4)**: 405–409.
3. Balkham A, Alderson S. 'The biggest car crash in NHS history': the media portrayal of GP pay before and after the introduction of the Health and Social Care Bill 2011. *Prim Health Care Res Dev* 2017; **8(1)**: 84–91.

DOI: <https://doi.org/10.3399/bjgp19X701429>

## Can QOF cancer care reviews help with continuity of care?

I write as an experienced GP, suddenly plunged into the world of a cancer patient and wish to reflect on the importance of a strong continuing GP–patient relationship throughout the cancer journey, and the role of QOF cancer care reviews in facilitating this process.

As a GP I have often experienced a mix of professional satisfaction and guilt when I've made an unsolicited phone call to a patient to perform a cancer care review. The usual driver for the call was to tick the QOF box, but, as the conversation has unfolded, patients have invariably expressed appreciation for the call and, although there is infrequently anything specific they have needed from me, it has been helpful to offer reassurance that I am available, should the need arise in the future.

Hurtand *et al* highlight the risk of loss of continuity of care with a GP around the time of, and in the year after, a cancer diagnosis.<sup>1</sup> As a GP, I had assumed that this was because of patients being absorbed into the hospital system, with multiple appointments and good support from cancer specialist clinicians. Although this is true in part, as a patient I have experienced a reality that is more mixed. I have encountered numerous

skilled and caring professionals, but have also recognised that they work within a system that is stretched and struggling to meet the demands placed upon it. Nowhere is this more apparent than the MDT process where the need to discuss large numbers of patients can result in rapid decision making and in the patient voice being marginalised. At worst, vital decisions can be taken by clinicians who have never met the patient.

As I've had my personal challenging encounters with this process, I have come to appreciate the value of a GP who knows me and my illness, and is able to listen and, where necessary, advocate for me. QOF cancer care reviews can provide a valuable doorway allowing patients to access this support. As a patient, I vote that they should remain.

Sally P Dillely,  
*GP, Beauchamp House Surgery, Chelmsford.*  
Email: [sallydillely@tiscali.co.uk](mailto:sallydillely@tiscali.co.uk)

### REFERENCE

1. Hurtaud A, Aubin M, Ferrat E, *et al*. Continuity of care in general practice at cancer diagnosis (COOC-GP study): a national cohort study of 2853 patients. *Br J Gen Pract* 2019; DOI: <https://doi.org/10.3399/bjgp19X700805>.

DOI: <https://doi.org/10.3399/bjgp19X701441>

## Evidence about complex interventions

I agree with almost everything McCartney and Finnikin say,<sup>1</sup> and am delighted that they have said it so clearly and succinctly. But I am concerned that they risk making 'systematic interrogation of all new healthcare policies for evidence and cost-effectiveness' sound easier than it is.

The traditional hierarchy of types of evidence places randomised controlled trials [RCTs] at the top, and this may well still be reasonable for evidence about a new drug or surgical procedure. But applying the same approach to evaluating complex interventions is increasingly acknowledged to be a mistake, because trial-based evidence