

symptoms with the relative efficacy and adverse effects of various interventions.

For men with mild to moderate urinary symptoms or bother, management by primary care physicians is appropriate. α Blocking drugs are the preferred pharmacological treatment for improving symptoms and flow measures regardless of the size of the prostate. Combining α blockers with finasteride provides no greater improvement in symptoms or flow measures than α blockers alone.⁸ α Blockers are associated with dizziness, asthenia, headache, and postural hypotension.⁹ They have not been clearly shown to prevent long term complications from benign prostatic hyperplasia or the need for surgery. Long term use of α blockers (for example, more than 15 years), especially for men with more severe symptoms may, result in net higher costs than initial surgical intervention. Phytotherapy preparations appear to provide modest improvement in urinary symptoms and flow rates and are well tolerated.¹⁰ However, the quality of existing data, long term efficacy, and purity of preparations is still in doubt.

Men with severe symptoms, urinary retention, recurrent urinary infections, incontinence, haematuria, or bladder stones should be referred to a urologist. If these conditions are due to benign prostatic hyperplasia, surgical or minimally invasive procedures are generally warranted. A systematic review of randomised controlled trials comparing transurethral resection of the prostate with transurethral incision of the prostate showed that while resection resulted in greater improvement in urinary flow rates the two procedures were equivalent in the more clinically relevant outcome of improvement in symptoms at 12 months.¹¹ Transurethral incision of the prostate resulted in a lower incidence of complications including the need for blood transfusions, risk of retrograde ejaculation, operative time, and hospital stay. Another systematic review compared transurethral resection of the prostate with laser techniques and showed that resection led to greater improvement in urinary symptoms compared with either non-contact or contact laser therapies. (R Hoffman et al, VA health services research and development annual meeting, Washing-

ton, DC, 2002). However, men treated with lasers had less morbidity and fewer complications, although many trials did not report adverse events. There were no differences between groups in the incidence of erectile dysfunction, retrograde ejaculation, or urinary incontinence. The findings by Brookes provide useful additional data.⁵

Incorporating the above information into shared decision making related to the diagnosis and management of benign prostatic hyperplasia is feasible. This approach will result in men choosing treatment options based on their personal weighting of the severity and bother of their condition with the relative risks and benefits of different options. It will provide high quality, cost effective, evidenced based health care and enhance patient satisfaction.

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A fresh new contract for general practitioners

Complex, with risks attached, but addresses many of the profession's concerns

The imposition of the 1990 contract by Kenneth Clarke was a blow from which professional morale among general practitioners has never really recovered. For many general practitioners it marked the end of a golden age. The "Red Book" has long been criticised as bureaucratic and inflexible, and the launch of personal medical services pilots in 1998 was an acknowledgment of the need for change. Currently, allocation of resources only poorly reflects patients' needs; the contract is highly focused on the individual practitioner and fails to recognise adequately the role of the practice team; quality measures are sparse and crudely applied; and perverse incentives often serve to reward poor quality services. A recent BMA survey exposed high levels of stress,

poor morale, and planned early retirement or exit from the profession.¹ The proposals for a new national contract, announced on 19 April jointly by the NHS confederation and the British Medical Association, mark an important departure.^{2,3} A new weighted capitation formula will replace the work of the recently abolished medical practices committee. Crucially, the national pricing of the contract will take into account the changing demands on primary care through an annual assessment of workload. If workload rises, new resources will be made available—a major victory for the profession's negotiators.

The new contract will be between a primary care organisation and a practice (rather than with an individual doctor), and services will be categorised as

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either essential, additional, or enhanced. All general practitioners must provide essential services, envisaged as a tightly defined core, but can reduce some of their current commitments. In particular, an opt out for out of hours care will be introduced, and in future these services will be managed through NHS Direct.⁴ Primary care organisations will have new responsibilities to commission alternative providers (not all of whom will be doctors) to fill any gaps created.

Conversely, those doctors who wish to will be able to offer enhanced services for extra pay. Some of these services will be nationally specified and priced; others will be open to local agreement. An expenditure floor will ensure that resources are available and not diverted to meet other priorities. A new quality and outcomes framework will cover standards to measure clinical and organisational quality and also patients' experiences. Thus, in part, doctors' pay may depend on the surveyed views of their patients.

So how well does the proposed new contract address the concerns of general practitioners? In future, general practitioners should be better able to control their workload and trade leisure for income. Importantly, the new contract proposes significant changes to the incentives facing general practitioners. Quality of care is likely to be a more powerful motivator than it has proved in the past. The perverse incentive for general practitioners to manage large lists with a limited range of services should reduce.

Shifting the contract from individual practitioners to practices introduces new incentives to make greater use of non-medical staff (under current arrangements, many payments are linked to the existence of a general practitioner). In addition, practices may become larger, with subspecialisation among general practitioners. Of course, the prospect of a practice based contract also raises questions about the nature of the contracting organisations, opening the door to new entities, including private limited companies, which have been tentatively tested under personal medical services.

The new capitation formula should be welcome for deprived areas because funding will be delivered regardless of whether general practitioners are already in post. Currently, many deprived areas are denied resources because enough general practitioners cannot be recruited.

The proposed new contract seems to offer much to general practice and to patients—but there are risks

attached. All incentives systems encourage gaming. General practitioners will inevitably concentrate on those quality targets that have been specified, at the expense of others. Whether the right standards have been incorporated into the new quality and outcomes framework will be disputed.

By clearly specifying general medical services for the first time the government risks paying for services it currently receives for free. Primary care organisations, too, face risks. The evidence from pilots of personal medical services suggests that active commissioning of primary care requires considerable managerial capacity.⁵ Yet primary care organisations are organisationally immature and overburdened.

The new contract raises important questions about the future for British primary care. Patients may receive services from their own registered practice, from another practice, from staff employed by primary care trusts, or from others such as community pharmacists. In addition, the linkage between daytime and out of hours services seems set to break forever, and domiciliary general practice visiting may be contracted out to a separate organisation. The traditional general practitioner will no longer be the only hub around which primary care revolves.

The negotiators have made much progress and have dealt with many of the profession's concerns, but the nature of the longitudinal relationship between patient and general practitioner, an admired hallmark of the British system, will change.⁶ This ultimately may be the most important consequence of the new contract.

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Childhood drowning is a global concern

Prevention needs a multifaceted approach

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Drowning is a significant cause of childhood death in many parts of the world. It is estimated that in 1998 almost half a million deaths worldwide were caused by drowning, 57% of which were among children aged up to 14 years.¹ A recent Unicef report found that, in 26 of the world's richest nations, injuries were the leading cause of death among children. Drowning was the second leading cause of injury related death, exceeded only by deaths due to road traffic crashes.² Drowning is also unique in

that case fatality rates are as high as 50% and medical care makes little difference in outcomes for victims brought to the emergency department without spontaneous respiration.

The study by Sibert et al in this week's journal (p 1070) identified a significant decline in the incidence of childhood drowning in the United Kingdom between 1988-89 and 1998-99.³ A strength of the study was the use of multiple data sources to identify circumstances surrounding deaths due to drowning.

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