LETTERS

All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding

The new GMS Contract

I am surprised that the *BJGP* saw fit to publish such a poorly researched and referenced editorial as that by Gnani and Pollock.[1] They base their inaccuracies on little more than an article in the *The Guardian*, one of their own papers about the Private Finance Initiative, and a paper produced by UNISON.

They try to suggest that the identification of such areas of work as child health surveillance, cervical screening, and vaccinations and immunisation as additional services under the new Contract will somehow bring about a fragmented service, while missing the point that, under the existing General Medical Services (GMS) Contract, practices need not get involved in many of these areas of work and in reality it is very unlikely that many practices will choose to opt out of providing additional services in the future.

Primary Care Organisations (PCOs) will not be pricing the bulk of the enhanced services as the authors suggest. They will be nationally priced, something those of us struggling to get local agreements and new local funding for new services will warmly welcome. And as such, the PCOs will have less of a role in local negotiations if, over time, practices move away from the locally negotiated Personal Medical Services contract to a nationally negotiated and protected GMS Contract. As such, the General Practitioner Committee will have a vital role in the future to protect our national Contract.

Gnani and Pollock go on to criticise the fact that practices will receive complete funding for the staff they employ. They seem to suggest that there is some current utopia, whereby practices can employ as many staff as they want using cash-limited monies. The reality is that practices up and down the country are crying out for more control over their staff budget. Practices are being constrained by PCOs from employing the staff the practice feels it needs. The new Contract will give the practice control, not the PCO. The current problems of PCO interference in practice priorities would be magnified if PCOs had any role in allocating locally a primary care budget, as the authors advocate.

The new Contract is not perfect by any means, but unlike Marshall and Roland's[2] critical review of the Contract's pros and cons, Gnani and Pollock have singularly failed to provide support for any of their assertions. To lead with a completely inaccurate and one-sided editorial about the new GMS Contract at such a sensitive time is frankly unacceptable.

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2. Marshall M, Roland M. The new Contract: renaissance or requiem for general practice? *Br J Gen Pract* 2002; **52:** 531-532.

Advertising in the *BJGP*

I was surprised and disappointed to see an advert in the April *BJGP* (page 311) advocating single vaccination over MMR when there is no evidence for this approach and when the latest figures for MMR vaccination have fallen.

I was not aware that it was College policy to condone single vaccination over MMR, as seems to be the implication by the inclusion of this advert in the *BJGP*. I hope this might be explained by an error in processing suitable adverts that are in keeping with the principles of evidence-based medicine and quality that the College usually promotes.

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The *BJGP* rightly prides itself on publishing work that informs the evidence base of our practice, and it was therefore all the more disappointing to discover an advertisement for 'WellCare' in the April *BJGP*, offering appointments for 'the single vaccination programme' under the heading 'A choice for MMR?'. The *Drugs and Therapeutics Bulletin* has published its review of MMR vaccine, and concluded that 'Such an arrangement [single antigen vaccinations] has no sound scientific basis and is likely to result in increased rates of disease' (*Drug Ther Bull* 2003; **41:** 29), and that 'the weight of published evidence argues overwhelmingly in favour of MMR vaccination as the most effective and safest way of protecting children'. We therefore suggest that the *BJGP* should not accept further advertisements from this, or any other, sources that are clearly likely to damage public health, and we ask that the Editor be more careful in his acceptance of material for the *BJGP*.

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Editor's note

Mea culpa (again). I approved the advertisement in question, on the basis that: (a) the standard for truthfulness to which we aspire for research papers does not have to be met for advertisements; (b) this advertisement was not claiming that separate vaccinations is a better policy than combined MMR; and therefore (c) did not contravene RCGP policy. A fuller answer is available on request.

The Beck Inventory — hidden cost

I would like to warn your readers that there is a cost involved in using the Beck Inventories. The Beck Depression Inventory (BDI) comes in a pack of 25 and costs £38.50 and each form can only be used once. The BDI is a complex instrument and need skilled interpretation to use it well. It is not infallible and false-positives and false-negatives can occur. There is little evidence that its routine use reduces 'risk', as claimed by your correspondents.[1] I think that it is about time that GPs stopped feeling guilty about missing depression. It is probable that all but a tiny handful of severely depressed patients (14%) are 'missed' by GPs. What is much more worrying is that many patients with mild to moderate depression are treated with antidepressants, which are ineffective, instead of being referred for brief therapy from a trained primary care counsellor, which we now know actually substantially reduces symptoms, increases wellbeing, and improves functioning in more than 76% of patients. Surely that's what we should be providing in primary health care.

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Reference

1. Graham P, Singh S. The Beck Inventory. [Letter.] *Br J Gen Pract* 2003, **53:** 324.

The ideal of personal care is threatened by politics and regulation but the lead letter in the April *BJGP*[1] reveals a much more ominous threat. The use of the Beck Inventory as an alternative to asking a patient if he feels depressed or has contemplated suicide suggests to me that the doctor is afraid of his own emotions. To pass the box of tissues, to look him in the eye, to touch his arm, would take less time than explaining the Beck Inventory and the patient would have experienced, however briefly, some human compassion. The doctor, if only he had been trained to the skill, would have received the gift of seeing into his patient's heart.

The Beck Inventory and similar questionnaires are useful tools for gathering statistics, but they have no healing potential. It may mean the encounter is 'painless to the doctor' but it will not make the patient feel any better. Surely our primary purpose is to ease suffering, not to 'crystallise an objective numerical measurement'.

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Reference

1. Graham P, Singh S. The Beck Inventory. [Letter.] *Br J Gen Pract* 2003, **53:** 324.

Graham and Singh's letter[1] advocating the wider use of the Beck Depression Inventory in general practice deserves enthusiastic support. It should be a basic tool of all primary care teams, being easy to use and providing an accurate assessment of mood that can be recorded in the patient's notes on a numerical scale ranging from 0 to 30 plus. As a rough guide, one may consider that people scoring 25 or more are severely depressed, those scoring 17 to 24 moderately depressed, while those scoring 10 to 16 have a mild form of depression. It is probably the most reliable questionnaire for assessing depression of those that are available and the scoring system enables the patient's mood to be monitored quite easily. This also makes it an excellent tool for research, which is perhaps why the first paper to be published with a statistical analysis by the *BJGP*'s predecessor, the *Journal of the Royal College of General Practitioners*, used the inventory to assess parental depression during pregnancy.[2]

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In defence of residential care visits

The ill-tempered letter from Nanavati *et al* (March *BJGP*)[1] should not go unchallenged. It seems that the attitude they adopt towards patients in residential care stems more from antipathy towards the owners and staff rather than interest in the patients themselves, who have little or no control over their own access to primary care.

I visit a social services home twice weekly. During these visits I deal with about as much trivia as I do in routine surgeries. I have more control over the length of consultations when I am visiting. However, the main advantage is that I know the residents well, so I am in a good position to act in their best interests when they become acutely unwell. Some elderly patients with a very poor quality of life may benefit from palliative care when they develop their final illnesses, rather than a 'hothouse assessment' in A&E where treatment is often impersonal and sometimes inappropriate.

Indeed, the major challenge facing our local health service is the huge number of elderly patients admitted to our local hospital, often inappropriately. Our local medical assessment unit has seen a 40% rise in referrals in three years, and with GPs such as Dr Nanavati seriously suggesting that ill patients in residential care can be accurately triaged by the GP over the phone, one can see one powerful

factor for this rise.

I contend that most of us from our own experience are aware that a grumpy 'put-upon' GP often makes poor clinical decisions. Good working relationships with residential homes are sometimes possible and where not, the GP at least owes a duty of care to the patient.

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Reference

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Sickness absence certification

Webb and Broome[1] put forward proposals for changing sickness absence certification. They raise important issues that require an informed debate among general practitioners.

There is a growing consensus that employers do need to take greater responsibility for sickness absence management.[2] Poor management of sickness absence can lead to long-term unemployment, with consequences for patients' health and well-being that are only too well known.[3] The best interests of patients are served where such management is informed by appropriate medical and specialist advice.[4] For example, more proactive consideration of workplace adjustments (as an alternative to advising patients to refrain from work) would help employers to develop healthy workplaces, reduce staff turnover, and improve compliance with anti-discrimination legislation.

Occupational physicians possess greater understanding of job demands and worker capabilities and are more used to communicating with employers on return-to-work issues than most GPs. They can also provide clinical leadership and advice to support job retention and workplace rehabilitation. Webb and Broome are right to point out the need for improved communications between GPs and occupational physicians to support this aspect of patient care.

However, occupational physicians represent a tiny proportion of the UK medical workforce and the vast majority of employees, particularly in private sector small- and medium-sized businesses, currently have no access to an occupational health professional.[5,6] Furthermore, GPs and other doctors provide advice on medical fitness for work to patients who have no employer, such as the self-employed and the unemployed.

It is true that the Government has commissioned research to explore the possibility of extending statutory certification to non-medical practitioners.[7] Currently, only registered medical practitioners, including of course occupational physicians, can complete the statutory forms (e.g. Form Med 3).[8] But some larger employers are already taking steps to reduce the GPs' role by seeking advice in relation to Statutory Sick Pay from their own occupational health specialists. Indeed, schemes very similar to the one outlined by Webb and Broome are currently being developed.

The official guidance to UK doctors is that, wherever possible, advice on fitness for work should be provided as an integral part of the clinical management of the patient's condition.[7] Interestingly, the Dutch approach cited by Webb and Broome has done nothing to reduce the adversarial divide between the treating GP and the occupational adviser, and there is little evidence that patients have been better served. Whatever changes may occur in the area of certification, the link between patients' health and their work means that GPs will continue to have a role in providing clinical care and patient advocacy, which supports rehabilitation.

The needs of working-age patients, in terms of clinical management and appropriate advice, should be the drivers of reform in this area. Important joint initiatives between the Department for Work and Pensions and the Department of Health, based upon this principle, are already underway. For example: Job Retention and Rehabilitation Pilots, which began in April 2003, will test alternative models to standard sickness certification, and from later this year 'Pathways to Work' schemes in England, Scotland and Wales will increase the rehabilitation advice and services available to working-age patients while hopefully further reducing the certification role of the GP.

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Patients' attitudes to GPs' use of computers

Almost all GPs now have desktop computers in the consulting room, and about 15% are running 'paperless' consultations.[1] Regarded as an essential tool, GPs not only use the computer for issuing repeat prescriptions and recording summary morbidities, but are also increasingly using computers interactively during the consultation to review and record notes, access results, write referrals, make appointments, and help support health promotion and screening.[2] With the government proposing to spend billions of pounds to introduce National Electronic Health Records by 2005 it appears that, in future, GPs will be spending even more time on their

*Table 1. Patient enablement as a result of computer use during the consultation (*n = *102).*

'As a result of the doctor using the computer in the consultation, I felt':	Number of patients responding (%)			
	Much better	Better	Same or less	Not applicable
The doctor was better informed about me	42 (41)	41 (40)	13 (13)	6 (6)
The doctor shared information with me	32 (31)	35 (34)	24 (24)	11 (11)
The doctor could look up information	65 (64)	24 (23)	2 (2)	11 (11)
I understood about my health and what was going on	32 (31)	31 (31)	30 (29)	9 (9)
I had time to talk about my health and problems	37 (36)	36 (35)	23 (23)	6 (6)

computers during the consultation. We know that computers may improve clinical performance and also increase the length of the consultation,[3] but could further increase in use affect the doctor–patient relationship in the future? We would like to report the results of our study, which sought patients' attitudes and opinions of their GP's present use of the computer during their consultation.

A random sample of 102 patients (59% participation rate) attending 10 GPs from three training practices in Belfast completed a questionnaire immediately following their consultation. The questionnaire enquired about their attitudes to their GPs' use of the computer during their consultation, and also measured patient enablement[4] as a result of the computer being used in the consultation.

The age range was 17 to 80 years (mean = 48 years). Fifty-nine per cent of patients were female and 27% were retired. Forty-four per cent stated they had no previous experience of computer use.

Half of the patients felt that the time the GP spent on the computer was 'about right' and 36% felt their GP used the computer 'not a lot'. Nearly all patients felt they knew the reason why the GP used the computer, listing prescribing, checking notes and recording history as examples.

Surprisingly, only 1% of patients felt distracted by the GP's computer and only 3% felt that the computer distracted the GP. All patients were happy with the way the GP used the computer, 99% felt it was good to have their records stored on computer, and 95% felt that the computer was useful in the consultation.

Patient enablement as a result of the computer being in the consultation also showed favourable results (Table 1). There were no significant differences in the responses with respect to patients' age, sex, GP or previous experience of computers.

Overall 98% of patients gave at least 8 out of 10 for satisfaction with their consultation. Free responses from most patients regarding the computer and its use in the consultation fell into the following themes:

- time-saving and efficient, i.e. for prescriptions and referring to notes;
- usefulness for the doctor;
- good for continuity of care; and
- avoiding errors.

Even though computers are being used more extensively in the consultation than in the 1980s, doctors can be reassured that nevertheless, as in the 1980s, patient satisfaction with the consultation remains high.[5] Earlier studies showed that patients, who had little previous exposure to computers, felt that the personal touch of doctors in the consultation might be lost.[6] In this study, 44 patients (44%) had no previous experience of using computers themselves, yet 42 of them (95%) replied positively towards the computer. Although this study gives no indication of the consulting styles employed by the GPs to incorporate their computer use in the consultation, we hope to explore this in a further study.

These results should not lead to complacency. With the implementation by the government of Electronic Health Records in the near future, it will be important that GPs can consult effectively while also using the computer. So are we turning our backs on our patients to use the computer? If we are, they don't seem to mind.

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Patients' views on respiratory tract symptoms and antibiotics

Respiratory tract symptoms, such as cough, earache, and sore throat, are the most common reasons why patients consult their doctors. Antibiotics are frequently prescribed for these symptoms, but shorten the duration of these symptoms only modestly, if at all.[1] Patients, however, appear to overestimate the effectiveness of antibiotic treatment[2] and their views are well known to influence prescribing decisions,[3] and therefore deserve consideration as possible determinants of differences in

Table 2. Views on respiratory tract symptoms and antibiotics of responders from The Netherlands, UK, and Belgium (Cronbach's α and mean per cluster).[a]

	α[b]	Netherlands (*n* = 247)	UK (*n* = 188)	Belgium (*n* = 243)
Response rate (%)		62	52	60
Age in years (mean)		40	45	41
Sex (% female)		64	56	66
In the event of respiratory tract symptoms:				
Need to consult a general practitioner	0.74	3.8	3.6	4.5
Perceived seriousness	0.82	3.6	3.4	4.2
Perceived self-limiting character	0.70	3.6	3.4	2.9
Antibiotics speed up recovery	0.82	3.3	2.9	3.1
Antibiotics stop deteriorating symptoms	0.85	2.9	2.8	2.8
Adverse effects of antibiotics	0.74	4.0	3.8	4.3

[a]Using a five-point scale (1 = strongly disagree; 5 = strongly agree). [b]Intercorrelation (Cronbach's α) between statements within the domains has been calculated after controlling of the grouping of statements by principal component factor analysis.

European outpatient antibiotic use.[4] An awareness of possible similarities and differences in patients' views between countries might be helpful in designing international interventions. We therefore compared patients' views on respiratory tract symptoms and antibiotics in The Netherlands, UK, and Belgium, (nations with low, moderate and high antibiotic prescription levels in primary care, respectively).

One hundred patients were randomly selected from the practice patient list of each of four general practices in these three countries. The practices were purposely recruited to represent areas with a wide range of social class and rural versus urban characteristics. The patients were asked to rate statements about respiratory tract symptoms and antibiotics[5] related to six different domains (Table 2). In total, 678 questionnaires were returned.

Belgian responders reported a greater perceived need to consult a GP with respiratory tract symptoms and considered these symptoms more serious and less self-limiting than responders in the UK and the Netherlands. UK responders were slightly less convinced of the need to consult a GP and of the seriousness of the symptoms than Dutch responders. The responders in the three countries were similar in their reported perception of effectiveness of antibiotics to speed recovery and to prevent respiratory tract symptoms from deteriorating. Belgian responders more often endorsed concerns about adverse effects from antibiotics, compared with the UK responders, with the Dutch responders adopting a middle ground.

Patients' sex and age were only slightly correlated with the ratings. Inter-practice variation within countries was small. Views about the need to consult, the seriousness of symptoms and the effectiveness of antibiotics correlated well with each other (Pearson's *r* ranging from 0.27 to 0.76).

There were smaller differences between the UK and Dutch responders' views as might be expected, given the differences in national antibiotic use. Countries' health care delivery characteristics (e.g. personal patient lists, peer review groups addressing prescribing behaviour, national guidelines on management and patient education, and physician availability) and doctors' views also may contribute to the international variance in antibiotic use.[4]

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Why do GPs see drug reps?

Prosser and Walley report on the social and cultural contexts of GP–representative encounters and identify six major themes encompassing the reasons why GPs see representatives.[1] Other studies, interviewing a smaller number of GPs, have acknowledged similar themes. GPs in Ireland regarded the interaction with representatives as promotional rather than educational, but did recognise the positive elements (information on new products, and a social aspect, especially apparent between established GPs and established representatives).[2] Personal education about new or existing products was the main reason why GPs in New Zealand saw representatives.[3] Others reasons included a feeling of politeness (patronage), an opportunity to get free gifts, and as a welcome break from the boredom of seeing patients.

Primary Care Organisation (PCO) prescribing advisers need to think through the implications of at least five of Prosser and Walley's six themes. How can PCOs provide GPs with timely, accessible, user-friendly product information? Do GPs value the quality of the encounter they have with PCO advisers and view the adviser as a legitimate, credible expert with whom they can build a long-term relationship? Is there any social interaction in the GP–PCO adviser encounter, and

do continued relationships actually develop? Is there a commercial context to the GP–PCO adviser, such as the offer of protected time or other resources enabling the GP to work on prescribing issues? Finally, can these visits become established as traditional and accepted practice?

These six broad themes describing the reasons why GPs see representatives do not fully match the techniques suggested as being of importance for changing behaviour by health service-led 'academic detailing'.[4] Marketing and academic visits are not totally equivalent because pharmaceutical representatives often support their activities with incentives (gifts), and these are not part of academic visits. Is this why health service-led 'academic detailing' does not appear to deliver as substantial a behaviour change across a range of practice sizes[5] as the approach adopted by the pharmaceutical industry?

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Tracking the fate of laboratory test results

Poor management of laboratory test results can lead to poor patient care and the risk of litigation. This is a report on a study conducted, firstly, to identify those test results not returned by the laboratory, and secondly, to explore the consequences to the patient if no system to monitor these was in place.

Four steps have been identified in the test result process,[1] but this report only concerns the first.

The study practice is an eight-doctor practice in Hertfordshire. Phlebotomy and microbiology tests were audited over a six-month period in 2002. The results clerk kept a copy of all test requests and, on return of the related result, noted its receipt. Each month overdue tests were identified and copies obtained from the hospital. A copy went to two doctors who independently assessed the action that should be taken. As the ranking of risk needs to be a value judgement,[2] a decision was made to rank the practical outcomes as they would occur in general practice. This ranged from 'no action' as low risk to 'referred to hospital' as high risk.

Over the six-month period, 3317 requests were monitored; however, because many of these were for multiple tests, the total figure was estimated as 7496. Of these, 36 (0.48%) were identified as missing.

The review by the doctors showed surprising differences (Table 3) with one doctor referring two cases to hospital while the other took no action. Further investigation showed that, although the hospital was involved, the loss of the test would not affect patient care.

However, the results show that there is a risk to the practice if test results are not monitored. Although small, the possibility of a significant error leading to litigation is present. The use of a dedicated results clerk with the associated costs is only one way to monitor the problem and alternatives were not investigated. There appears to be no computer program to track results at present, but paper is costly and time-consuming. Literature searches have found there is little evidence on best practice to assist us.

The large number of 'no action' decisions also raises queries about the clinical need for some tests.

Missing test results are only one part of the process. Unless practices ensure that their system is robust enough to manage all four steps, quality care will suffer and costly settlements continue.

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Changing clinical behaviour

It was with interest that I read the paper by Baker *et al* in the April *BJGP*,[1] and the related editorial,[2] both

Table 3. Analysis of GPs' assessment of missing test results.

	Jan	Jan	Feb	Feb	Mar	Mar	Apr	Apr	May	May	Jun	Jun	Total	Total
	Dr A	Dr B	Dr A	Dr B	Dr A	Dr B	Dr A	Dr B	Dr A	Dr B	Dr A	Dr B	Dr A	Dr B
Refer hospital									1		1		2	0
Urgent appointment													0	0
Routine appointment	2	2		1									2	3
Script given					1						1		2	0
Further tests	2		4				2		1				9	0
No action	1	3	4	7	3	4	1	3	3	5	9	11	21	33
Total	5	5	8	8	4	4	3	3	5	5	11	11	36	36

relating to guidelines and changing clinical behaviour. Baker produces, as usual, an excellent piece of work; yet, surprisingly, while accepting that getting guidelines into practice is difficult, seems not to recognise previous work, which clearly identifies that this only has any chance of coming about when multiple methods are combined. Grimshaw and Russell[3,4] recognised that there is not, and never will be, a single 'magic bullet' bringing about guideline implementation. Guidelines need to be combined with education, behavioural methods such as feedback, marketing techniques, organisational factors, social pressures, and economic factors, to have any chance of becoming part of everyday practice.

Why is it so difficult to bring about the use of guidelines? One major factor is that we are dealing with professionals. Primary care professionals are working, not in a clear scientific field, the high ground, but in what Schon has described as 'the swamp' — the uncertain world of general practice.[5] A key professional skill is the use of judgement. This is what primary care professionals have to use every day, because sadly most guidelines do not cope with life in the swamp, missing the complicated big picture of life there, while dealing scientifically with the many involved components. David Jewell has hit the nail on the head in his editorial. What is required to bring about change in clinical behaviour is leadership in a practice, relevance of change to local and practice needs, and the capacity to give time and resources at practice and locality level. This was confirmed by my own work.[6] What he is enunciating are the new values now required by professionals in this century, yet these seem to be espoused only by a proportion of practitioners.[7,8] Leadership and the ability to look outside the practice to see a slightly bigger picture still need development in general practice. This professionalism must however develop, as without it significant developmental change will always have difficulty coming about in general practice.

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Cynicism in GP tabloids

I read David Tovey's article[1] with vulgar amusement. Does he not yet realise that the plebs are revolting, that *hoi polloi* are raucous, and the great unwashed are smelly?

He clearly does not know me. I confess myself entirely self-respecting, and an avid reader of both the medical newspapers and the medical journals. Why do we affect to esteem journals so much yet so despise the craft of journalism? And yet despising the craft of journalism as a profession we probably read newspapers more avidly than journals because they are eye-catching, better written, and better presented than journal articles. You may not realise this, but this is part of the skill of the journalist.

Tovey draws a false distinction between the *BJGP* and medical newspaper readers, and so then goes on to ask the wrong question. The question should not be about why writers like Tony Copperfield find an audience, or why Copperfield became a doctor. It should be about the events in life through which it is possible for the bright, young medical graduate to turn into a cynical older doctor. Some people call this realism or maturity. I call it tragedy. Personal growth in medicine is to learn to transcend this tragedy, but we are all wounded to some extent and so if at times we snarl like wounded tigers, this may accurately reflect our present state.

This tragedy has been played out for years, and the results of medical psychopathology, including my own, can be seen displayed every day on www.doctors.net.uk and weekly in the medical newspapers. It serves the minimal function of splenic ventilation, and the useful function of reflecting the mood of the profession. Others may well be worse off than us but that is no blessing to us, or them.

Currently in medicine the peasants are both revolting and in revolt. This may not be an attractive sight, but it represents the efforts of intelligent people to keep their sanity intact in a world that has lost its sense to them. Hippocrates proposed that 'Primum non nocere' should be a guiding principle of our profession. We have never applied this to ourselves and to each other. Perhaps it is time not to shoot the messenger, but to start to respond to the symptoms of distress from our hurt profession and our hurting selves.

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Corrections

In the May issue of the *BJGP*, we incorrectly described Professor Allyson Pollock (page 355) as a Professor of General Practice. Her correct title is Chair of Health Policy and Health Services Research at University College London and Director of Research & Development at UCL Hospitals NHS Trust. We apologise to Professor Pollock for the error and for any embarrassment this may have caused.

Also in the May issue, we incorrectly quoted the e-mail address for correspondence with Dr J Gervase Vernon (page 399) as gervase@jtm.demon.co.uk. The correct address should have been given as gervase@jth.demon.co.uk. We apologise for any confusion this may have caused.