record with no attempt to balance the debate or explain the systems that are being proposed.[1]

It is irresponsible to publish commentary on such an important issue for patient safety and confidentiality without the necessary balance expected from an academic journal. To promote a single agenda in such a blatantly campaigning way without an accurate representation of the facts in our view does the Journal, the College, and our patients a great disservice.

The editorial by Professor Ross Anderson seriously misrepresents the current consent model of the summary care model. Professor Anderson who is an advisor to a political campaign to get patients to opt out of the current arrangements also encourages GPs to support the campaign. Even the Editor himself seems to promote this view in his own comments, he challenges; 'Anyone going to join the opt-out campaign?'

The Big Opt Out campaign seems to be based on misinformation and has a much wider political context. To quote from the explanatory paragraph on the website:

> *'The NHS Confidentiality campaign was set up to protect patient confidentiality and to provide a focus for patient-led opposition to the government's NHS Care Records System. This system is designed to be a huge national database of patient medical records and personal information* [sometimes referred to as the NHS 'spine'] *with no opt-out mechanism for patients at all'.*

We should be informing our patients that for the summary care record this statement is not true and as clinicians we have a professional duty to inform our patients in a responsible and balanced way, and point them to reliable sources of information.

The *BJGP* has given the impression of promoting a campaign to encourage patients to opt out of the summary care record in a way that risks undermining patient care on the basis of an inaccurate and biased position. There is no balancing of the Big Opt Out Campaign position with what is actually happening in the early adopter areas and what measure of control patients have should they wish to limit their participation. These measures are being independently evaluated and for an academic publication it is disappointing there is no mention of this.

In the same edition the article by Gordon Baird on the experience of an emergency care record in Scotland is equally biased away from central patient databases.[2] He even admits to encouraging his patients to opt out of the system by sending a letter to his patients that gave 'a rather unbalanced view.' This is particularly unfortunate as the Scottish emergency care record is widely felt to be a success. It is used by GP out-of-hours services and by emergency departments and is popular with both doctors and patients.

Dr Clare Gerada offered the support of the College only 2 weeks ago during the Summary Care Record Advisory Group when we discussed the problem of myth and misinformation that is clearly being pushed out at the medical profession.

Although we understand that the *BJGP* has editorial freedom, it seems to be embarking on a campaign and if this was not the intention then the judgement of the Journal must be called into question. It is worthy of note that last year an article that was offered on changing the face of referrals and Choose and Book by Dr Mark Davies, Medical Director of Choose and Book, at the time was turned down by the Editor on the basis that he was biased.

Since there is a full month until the next edition of the *BJGP* much harm could be done to the GP perception of the College position until that time. We have received a number of enquiries already asking us if this is the new RCGP policy position.

We would be grateful for a statement clearly distancing the College from the position taken by the editorial. We would also like an opportunity in the Journal to give a more balanced view and address some of the myths that have now been promulgated.

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Manpreet Pujara
National Clinical Lead for General Practice, NHS Connecting for Health.

Peter Short
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On strengthening primary care

De Maeseneer, *et al*'s[1] editorial reflect our experiences delivering health care in the rural areas of Malawi's central region.

Our NGO's initial work was in AIDS orphan support and AIDS education; in every village we found a significant number of children needing medical attention for acute and chronic conditions. Investigation found they had no practical access to medical care, because of poverty and geographical location. Typically the tarmac road would be over 25 km away and the nearest health facility a further 40 km. If the sick child made the journey, the choice would be between a government hospital where treatment, although free, is limited from chronic shortages of clinical staff and pharmaceuticals, or the mission sector where treatment is paid for, often beyond the means of the poor.

Our response was to set up a children's mobile clinic, taking primary health care to the villages. Utilising 4 x 4 vehicles stocked with a wide range of medicines, our team of clinical officers and nurses treat over 30 000 sick children annually.

On our busiest day in 2007, our two

Malawi clinical officers and a volunteer doctor from the UK dealt with 407 patients presenting with a full range of tropical diseases seen in Central Africa, including those targeted but as yet not reached by the listed Global Fund vertical programmes. The fact that the children's parents/guardians will travel for up to 2 days to be seen by our team indicates their lack of alternatives. Vertical programmes will never reach these children.

We have expanded our programme to include a mobile operating theatre for minor surgery in the field, vaccines to support the national immunisation programme, antiretroviral drugs (ARVs) for PLWA children (children under 13 years of age with AIDS were initially excluded from the Malawian ARV roll out) and in partnership with UNICEF, an initiative in the prevention of mother to child transmission of HIV through prophylactic ARVs and exclusive breastfeeding for the first 6 months of infancy.

A key part of our work is integrating care with other healthcare providers, making cost-effective primary health achievable. Those diagnosed with conditions requiring specialised treatments have their transfers facilitated without the need for other levels of bureaucracy.

Our experiences persuade us that this form of primary health care is the most effective use of donor money.

Michael Burt
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DOI: 10.3399/bjgp08X277393

Authors' response

We thank Dr Burt for his comments and would like to compliment him on his response towards the population's need in precedence over the pursuit of the vertical programme. In fact his experiences underscore the point we make: the importance of comprehensive, horizontal primary care for population health. Burt, in an elegant way, has merged the horizontal and vertical approaches, by using facilities of the AIDS programme to improve overall care in the community. In our view, this should be approached in a structural way, by running disease-specific programmes through community-based primary care, and investing a small part of the programme money to strengthen the structure of integrated, horizontal primary care.

Dr Burt's comments stress also the point of durability. His impressive example demonstrates what highly trained and motivated GPs can achieve even when modest extra resources are made available to primary care. The training of GPs and other primary care providers in the community, and at the same time investing in their ability to provide care, is in all probability the best way to guarantee access to care where it is most needed: out, in the community.

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Appraisals

I am an ordinary jobbing GP in a non-training practice focused on delivering a good service to my patients. I find the current appraisal system irksome rather than helpful and so I turned to the article in the February 2008 issue[1] with interest.

I am glad that someone is looking critically at the system but the background of the authors concerns me. Three out of the four authors are employed by or have close ties to the organisation involved in devising and implementing the system. I am sure that they are honourable people, but I think it may be difficult to be objective about a system to which you have devoted much time, energy, and emotion. The study was funded by the bureaucracy that stands to benefit by keeping it going. We rightly criticise drug companies for that sort of thing. Would we ask an architect to investigate why his radical new building collapsed? I would have preferred an independent research body such as the Kings Fund or similar.

The authors comment towards the end that the value of the process declines with repetition but that those GPs who found the first appraisal valuable continued to do so.

I would certainly support the first point. Large parts of my preparation for this year were simply cut and pasted from last year. As to the second point, perhaps the process should be voluntary and only for those who find it valuable? The percentages in Table 1 measuring the utility of appraisal against a broad range of descriptors show a poor rate of return for all the effort.

The only form of appraisal worth anything to me or my patients is to be measured against a clear set of accepted and evidence based criteria. Until they can be agreed and properly tested, leave me alone with my professional responsibility.

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1. Colthart I, Cameron N, McKinstry B, Blaney D. What do doctors really think of the relevance and impact of GP appraisal 3 years on? A survey of Scottish GPs. *Br J Gen Pract* 2008; **58(547):** 82–87.

DOI: 10.3399/bjgp08X279526

Corrections

In the February issue of the journal, the authors of the letter 'Sexual enquiry in older people' were ordered incorrectly, they should be Elizabeth Starren, Gareth Walker and James Warner.

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