

can also do harm.

However, it is the statement that 'Not to have incentivised GPs to identify a group of people who were more at risk clinically ... would have been negligent' that is truly outrageous. Here there are QOF points for applying a universal method that also has substantial error rates, with the possibility again that this will lead to over and under identification. Dr Cohen here has subscribed to the suggestion both damaging and now proved to be erroneous, that GPs will only take action that is financially rewarded. If the lie were correct, then what is the implication for all those other patients with long-term disabling conditions, also at higher risk of depression? Or is he suggesting that this QOF provision should be extended to all patients? In which case it would become, effectively, a screening programme for which, again as Toop points out, there is no convincing evidence.²

The QOF approach began as a limited set of targets to encourage more universal application of a number of measures that were backed by sound evidence and generally accepted as both achievable and beneficial. It has gradually expanded to incorporate more dubious measures that command less acceptance, and looks more and more like a set of hoops to make recalcitrant GPs work harder with little extra gain for patients. Meanwhile, the clamour from numerous lobby groups for inclusion of their pet measures in the QOF continues to grow. Not only de-professionalising, but very depressing and sadly, all too predictable.

David Jewell,

20 Duchess Road, Bristol, BS8 2LA.
E-mail: david.jewell66@googlemail.com

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Primary care electronic health records: who is in control?

As a late adopter of electronic health

records, apart from repeat prescribing, I was reluctant to leave my efficient paper practice notes that I controlled and wrote my patient's narrative. It is now routine to record such contacts on the computer record but my eyes rarely lift from the keyboard. At the same time part of my mind is involved with the software set-tasks, often government driven, that need to be slavishly tackled in order to gain essential payment. I warned my past colleagues that this was the electronic hamster wheel of the medical primary care workload and they have nearly all retired early. I am still at the primary care coalface but this is due in part in trying to wrest some personal control of this electronic record in order to aid my patient care.

Here I refer to the recommendation to use clinical indications on all repeat prescriptions, which is an excellent use of the repeat prescription electronic process, described in detail on my website.¹ The latest draft of the GMC guidelines on good prescribing recommends that all doctors should consider including such a process in their prescribing.² Smoking recording is another area that has needed revisiting and my smoking pack year calculator³ provides a smoking exposure dose on those 'ever smokers' so that smoking is searchable and potentially predictive. In addition I have developed some paediatric drug dosage calculators to aid my busy everyday work. These self-created additions have given me the much needed personal 'locus of control' of the electronic health record, but will scream in the face of industry standard setting and may make it impossible to transfer my detailed data reliably from GP system to system. Still I cherish my patient's records in our small practice and a recent letter from a young consultant vascular surgeon unprompted said it all ... 'The computerised notes summary in your surgery is extremely impressive'.

Nigel Masters,

GP, Highfield Surgery, Highfield Way,
Hazlemere, Buckinghamshire, HP15 7UW.
E-mail: nigel.masters@nhs.net

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Electronic health records: research into design and implementation

I was surprised that the only systematic review referenced in the editorial on electronic records in your October issue¹ was 10 years old and based on studies of record systems that are long obsolete.² The editorial failed to mention a 2009 systematic review by my own team, that summarised 24 previous systematic reviews on electronic records (including Mitchell and Sullivan's) and that offered a new synthesis of primary literature from the organisation and management literature, including but not limited to actor-network theory approaches.³ The editorial also failed to mention the 2011 'review of reviews' of e-health applications by Ashly Black and colleagues, that summarised 108 previous systematic reviews on electronic records and other information and communication technologies in health care.⁴ While this editorial made some good points and referenced some of the important recent studies and commentaries in this area, it was 'freely submitted, not externally peer reviewed' and illustrates the dangers of such a policy.

Trisha Greenhalgh,

Professor of Primary Health Care and
Director, Centre for Primary Care and
Public Health, Blizard Institute, Barts and
The London School of Medicine and
Dentistry, 58 Turner Street, London, E1
2AB. E-mail: p.greenhalgh@qmul.ac.uk

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Alcohol and pregnancy

In their national survey of post-pregnancy follow-up of women with gestational diabetes mellitus, Pierce and colleagues found a lack of adherence to National Institute for Health and Clinical Excellence (NICE) guidelines.¹ NICE have recently updated their recommendations of safe alcohol limits in pregnancy, but it is unclear whether people are aware of the new guidelines. Having previously recommended no more than one unit of alcohol per day during pregnancy,² NICE now recommend no more than one or two units a week.³ NICE also advise avoiding alcohol completely in the first trimester of pregnancy.³ Although recommendations vary, all guidelines emphasise the danger of binge drinking.²

In September 2011, we carried out a questionnaire survey of women aged 16 to 40 years to investigate their knowledge of the new guidelines on safe consumption of alcohol during pregnancy. Women sitting in or walking through Leicester Square, London were given a patient information sheet and asked if they were willing to complete a brief, confidential questionnaire on alcohol in pregnancy. The questionnaire asked how many units of alcohol are recommended as safe during pregnancy and in which trimester of pregnancy it is safest to drink.

The response rate in 186 eligible women was 54% (100/186), and their mean age was 23 years, 97 correctly said the recommended level was no more than one or two units a week, of whom 79 thought no alcohol should be consumed during pregnancy. However, three women thought it was safe to drink one or two units daily. All 99 women who responded to the question agreed that it is unsafe to drink five units of alcohol ('binge drinking') at one sitting during pregnancy. However, contrary to the guidelines, a third (32/99) of women thought that drinking was safest in the first trimester.

This survey showed the majority of participants knew the safe alcohol levels recommended during pregnancy in the new NICE guidelines. However, the study did reveal that a third of women incorrectly presumed that it was safer to drink in the first trimester of pregnancy. Perhaps, by increasing awareness, more women will avoid alcohol during this trimester.

However, many pregnancies are unplanned, some may be associated with binge drinking, and women may unwittingly drink in the first 3 months of pregnancy before they know they are pregnant. Pierce and colleagues suggest education of women about the need for follow-up after gestational diabetes mellitus is important.¹ We suggest another role for primary care may be to continue education about safe alcohol limits, especially during the first trimester of pregnancy.

Gloria Jesuratnam,

Medical Student, St George's Medical School, University of London, SW17 0RE.
E-mail: gloria_j@hotmail.co.uk

Pippa Oakeshott,

Reader in General Practice, St George's Medical School, University of London.

Raja Mukherjee,

Consultant Psychiatrist for people with LD (Tandridge), Lead Clinician Specialist FASD Behaviour Clinic, St George's Medical School, University of London.

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The Olympic legacy

It was with surprise that I read Mike's Fitzpatrick's assertion that exercise is 'deemed virtuous but has no proven value in relation to health'.¹ Skimming through over 40 references in the Department of Health *Lets Get Moving* commissioning guidance² made me feel that Mike needs to

spell out the reasoning for his claim a little more robustly.

Rachel Pryke,

GP, Winyates Health Centre, Redditch, Worcestershire, B98 0NR.
E-mail: rachelgpryke@btinternet.com

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Physical inactivity is associated with earlier mortality — the evidence is incontrovertible

We commend *BJGP* for publishing and bringing much needed attention to the opinions of Mike Fitzpatrick on the perceptions of physical activity promotion within the healthcare sector in this country.¹

There is, however, nothing virtuous, propagandist, patronising, and infantile about physical inactivity being the fourth leading risk factor for global mortality responsible for 6% of worldwide deaths and a major contributing factor to 60% of global non-communicable diseases.² There is a clear causal relationship between the amount of movement people do and all-cause mortality.³

Behaviour change psychology permeates all aspects of medicine and it is interesting to note that, despite widespread acceptance of pharmaceutical medications by doctors, enormous pharmaceutical advertising expenditure, and a large proportion of medical education being devoted to pharmacology, only 30–50% of patients change their behaviour sufficiently to consume prescribed medication at advised therapeutic doses.⁴ Changes to medical education are urgently needed to include greater emphasis on behaviour change techniques for they underpin much of what we do in clinical practice, and are effectively used to modify physical inactivity behaviour