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Access to primary care and distance from PCC

O'Reilly and his colleagues[1] in their study of out-of-hours services concluded that there might possibly be inequity in access with increasing distance from the Primary Care Centre (PCC), commenting that with 'all other things being equal the likelihood of face-to-face consultation with a doctor decreased the further that the patient lived from the PCC'.

It is impossible to tell from this study whether they have thoroughly investigated if patients who live further out of towns, where PCCs tend to be situated, are those who seem to be generally able to cope with life better and therefore less likely to call. One thing that they do not seem to have taken into account is that those with serious illness tend to move out of rural areas into towns where it is easier to access services.

For example, whereas a fit 85-year-old might continue to live on a family farm or in a country cottage, an 85-year-old with several chronic diseases and poor mobility would tend to move in to town, to be closer to the shops and other services. This is definitely the trend that I have seen in my semi-rural practice and I feel that this is possibly an area which ought to be further researched before reaching any definite conclusions on this matter.

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Vocational training in Europe

In the article 'The case for strengthening education and training for general practice' by Professor Tim van Zwanenberg (May *BJGP*, page 348), which stated that:

'There is substantial variation in the duration of training across the member states of the European Union, ranging from two years' training (the minimum allowed under European Council directive 93/16) in Iceland, Belgium, and Italy, to five years in Norway. However, longer periods of the general practice element of vocational training are found in Europe and elsewhere in the world. In Australia and Holland, the programme is three years in duration with one year spent in hospital-based rotations specifically attuned to general practice. Among the Scandinavian countries, there is a five-year programme in Finland with two years spent in practice; a four-and-a-half-year programme in Sweden with two years spent in practice, and a five-year programme in Norway with four years spent in practice.'

This is a misunderstanding. Most GPs in Iceland receive formal vocational training in general practice lasting, on average, four-and-a-half years, which consists of two years' training time at a health centre plus two-and-a-half years in other medical specialities. The majority have been trained abroad in Scandinavia, Canada, the United States, and the United Kingdom. Included in the training period are tutorials and theoretical education.

It is also possible to do the training in Iceland and this is becoming more popular since the organisation of training has been improved. In spite of this, many move abroad for their vocational training, not least to widen their horizons. The result is a workforce in general practice with diverse backgrounds and experience. This has been positive in many regards although, as in other countries, we face recruitment shortage problems.

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Chronic pain

The high prevalence of chronic pelvic pain (CPP) in women in their reproductive years, and its co-presentation with sensory bowel and bladder symptoms, poses a considerable burden in primary care.[1] Persistent pain following a negative laparoscopy, or hysterectomy, is all too common and frequently defaults to the general practitioner. There may, however, be some grounds for optimism.

Many women with clusters of sensory pelvic symptoms have had a prior, difficult intrapartum episode five to ten years previously, with avulsion of the levator ani from the pelvic side wall demonstrated by magnetic resonance imaging.[2] The most frequent antecedents are premature (before full dilatation) or prolonged (more than two hours) maternal voluntary efforts.

Clinical examination reveals point tenderness in the right suprapubic area (sometimes bilateral) where the superior fibres of the arcus tendineus levator ani have been avulsed. Subsequent studies in similar groups of patients have shown evidence of denervation and reinnervation of the uterus.[3] The possibility exists that many sensory pelvic symptoms result from reinnervation following a denervatory intrapartum episode.

Sensory bladder and bowel symptoms respond promptly to antimus-

carinic agents, e.g. oxybutinin, tolterodine, trospium, etc. A significant proportion of patients with sensory gynaecological symptoms, including chronic pelvic pain, respond to GnRH agonists. Despite these potentially helpful therapeutic options, the most effective management will include a full explanation of the causes and consequences of the injury based on a precise clinical history and careful physical examination.

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Blair Smith's Editorial (July *BJGP*, page 524) and Zondervan and colleagues' paper on pelvic pain (July BJGP, page 541) focus on the incidence and impact of chronic pain.

From the perspective of running a chronic pain management programme, which is the point of referral of last resort for many patients with chronic pain, some themes exist that are crucially relevant to general practice.

First, the cause of the chronic pain must be elucidated. Many patients present with a chronic pain syndrome and yet have not been re-examined by their general practitioner. A small but steady stream of previously undiagnosed conditions are found, which are amenable to disease modification. Among the remainder, the development of the chronic pain syndrome is often closely linked to psychosocial distress. Insult to the sensory nervous system, be it through disease, surgery or injury, can result in ongoing chronic pain. Abuse of all types, coupled with low self-esteem, is a recurring aetiological factor. Depression may worsen the patients' experience of their chronic pain; however, many patients express anger at having been 'labelled as imagining their pain'.

Secondly, these patients have entered a cycle of repeated prescriptions from which they have unrealistic expectations, and from which they suffer a myriad of side-effects. This cycle also fuels their medical dependency as they search for the 'magic bullet'.

Thirdly, these patients need a de-medicalisation model to learn to cope with life in spite of their ongoing chronic pain, which has not responded to standard analgesic prescriptions or other medical interventions.

Our plea is that the diagnostic duty of the doctor is not forgotten behind the label of chronic pain. Chronic pain is often a marker that many things are wrong, touching the physical, emotional, social and spiritual aspects of a patients' being. To unravel these issues and move patients forward in their understanding requires an explanation of the pain, including gating and why analgesics ('painkillers') do not 'kill pain'. This then helps the patient to understand their chronic pain syndrome.

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Missed appointments

With reference to Neal *et al* (October *BJGP*, page 830), I have noticed that the number of my missed appointments has risen significantly this year as my accessibility has declined. From being very rare I now often have more than one DNA per surgery which, with ten-minute appointments, is a significant waste of time. This coincides with the wait for an appointment changing from being in the next day or so, to at least a week.

Practices involved in the Primary Care Collaborative who guarantee an appointment the same or next day report a reduction in missed appointments. We are not going to change our patients' characteristics and no doubt some people will always be unreliable. However, it is possible for us to reduce the number of missed appointments with improved systems of working.

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TRIPS

Dorothy Logie (September *BJGP*, page 773), in her article in the Back Pages 'Patents, prices, and public health', suggests that the way forward includes 'cutting the cost of medicines and shifting the balance of patent laws in favour of the poor'.

Why do we rely on drug companies to produce new drugs through R&D? A good first step would be to remove the shareholders — and their demands for dividends — from the process and for national governments to develop new drugs on a co-ordinated basis at national research centres, such as universities, so that ownership of the results is definitively within the public realm. Not only would it lower the costs of dividends in the pricing of new drugs, but it would allow priorities in disease areas to be researched according to a planned agenda that may be influenced by public health concerns, rather than market economy.

Britain should start the trend. After all, we have precedents, in our public universities and our Parliament has a history of buying and owning patents to many useful drugs (and also quack remedies) in the past.

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Single-handed practice — the reality

It is with sadness that I read the article 'The end of single-handed practice?'[1] and it is with corresponding regret that I feel I have to reply.

Harold Shipman is a killer who happened to be a single-handed general practitioner; there is no evidence that he killed patients because he was a single-handed doctor. Harold Shipman

left a trail which should have alerted the authorities much earlier that this was a person at risk. The greater-than-average number of deaths per year of patients in his care, the greater-than-average number who died at home or in his surgery, and the failure of the authorities to act earlier, all point to a failure in a system that allowed Harold Shipman to practice medicine and so afforded him the opportunity to continue with his gruesome acts.

Notwithstanding the view of Frankel *et al*,[2] it is important for general practitioners to keep a record of deaths in their practices. A simple record of the cause of death, where the death occurred, and numbers, should in my view be sufficient to alert authorities to persistent variations from the norm that require investigation. I have for some years now maintained a register of deaths in the practice and, despite small numbers, find the register of use. PCG/T's could take on a monitoring role in this respect. This could also be a useful educational/planning exercise.

Peterkin and Coid draw attention to the difficulties in managing illness in a doctor in practice. With the current shortage of locums, illness and absence of a doctor is a problem in most practices, large or small. However, with PCG/Ts taking an active role practice affairs this should not be any more of a problem in a single-handed practice than in a larger one. Suboptimal performance is as likely to occur in a larger practice as it could in a single-handed practice — it is more a function of the practitioner than of where he/she practices.

It is said that 'there is no system of education yet devised that could hold back a good student'. It is easy for poor practice to be submerged and even go unrecognised in a large practice. Kennedy,[3] in his report into the Bristol cardiac deaths, warned the profession against a 'club culture', which seems to have pervaded all levels of medical practice. It is important for all practices to be the subject of performance audits.

There is no justification for a greater burden of performance assessment for single-handed doctors. Floyd and Evans[4] found that smaller practices were better at providing information and results care than larger practices, which they viewed as having difficulties with chronic disease management, data entry, and audit. Hippsley-Cox *et al*[5] found no evidence of underperformance by single-handed general practitioners. Interestingly, Campbell *et al*[6] found that no particular practice type could claim a monopoly on quality.

In my PCT, all practices contribute to audits which are run by Equip, the successor to the Multidisciplinary Audit Advisory Group (MAAG). Performance of each practice is set out in the results; comparisons with other practices in the locality and other localities in Health Authority are available. This information is available to our PCT for use in its own audits of performance and for local clinical governance.

With the advent of PCG/Ts, isolation in general practice is disappearing. There are more frequent meetings with colleagues and collaboration at PCT/G and locality levels to an extent which was unthinkable even three years ago. As a single-handed doctor I would not agree that my performance is suboptimal in any system of assessment currently available. Some of the activities in my practice include: asthma care provided just as in any larger practice, with no referrals to secondary care in the past three years; no referrals for minor surgery in the past 20 years; consistent attainment of the higher performance targets; regular audit; and involvement in FBA, MAP, appraisal, etc.

If I am under performing then I shall certainly take the necessary steps to correct deficiencies in my practice, as indeed should be the obligation of any doctor. Herein lies the crux of the matter — all doctors should be accountable, primarily to their patients, and more widely to the NHS and the public.

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Chronic fatigue syndrome

Professor Murdoch in the September *BJGP*[1] uses his study of Down's syndrome,[2] which demonstrated that mothers had an increased number of reported illnesses in the year before the birth, to undermine our interpretation of the findings in our chronic fatigue syndrome (CFS) study in the July *BJGP*.[3] He asks why anyone should believe CFS is caused by behavioural factors.

However, the apparent similarities between the studies are superficial. We studied consultations over 15 years and examined many disease categories. He studied one year, and all conditions from psoriasis to malignancies were analysed as a single category. Most importantly, in Down's syndrome there is an established mechanism to account for the clinical findings and his study examined factors that might explain germ cell non-disjunction. Indeed, it is entirely plausible that such illnesses might contribute to such a process.

However, no such abnormality has been demonstrated with CFS. Extensive searches for immunological, infectious or endocrine explanations have drawn a blank. Therefore, it is entirely possible that our findings of increased general practitioner usage for up to 15 years before development of CFS represent a behavioural problem. We simply ask CFS researchers and clinicians to examine their hypotheses and beliefs against our findings and see how well they match.

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Equal and opposite reaction to Willis

In his article,[1] James Willis appears to take pleasure in pointing out the fallacy of Newton's fundamental scientific theories and to imply regret at their ascendancy in modern society, at Blake's expense.

William Blake was an undoubted visionary and his influence was essential to temper or balance the incredible scientific advances of his age, but his opinions of Newton, who predated him by a century, are poor grounds for Willis' attack. With the benefit of time and the intervention of other scientific geniuses, it is easy to describe how Newton 'got it wrong'.[1] Nevertheless, Newton established the closest proximity to the physical 'truth' that was possible at the time. Only with his contribution have subsequent advances been possible, including those which proved his theories 'wrong' (or not wholly correct). To disdain Newton for this is equivalent to laughing at the author of *Beowulf* for his or her primitive spelling and grammar.

In 1675, Netwon admitted 'If I have seen farther, it is by standing on the shoulders of giants',[2] and the same is true of his successors. Newtonian physics have provided a perfectly functioning model of the world for all practical purposes for over 300 years and will continue to do so for most practical purposes. Calling on Einstein to denigrate Newton is a poor attack against numbers and scientific theory.

It is fashionable in primary care science to denounce numbers,[3] but we assert their virtues, including objectivity, constancy, and transparency. Words and numbers are independent, both are required to approach an understanding of the world and its patients, and both form the basis of human thought. As Willis states, 'numbers can simplify and distort', but so can words, as he has demonstrated.

While it is clear that Newton's influence will prevail for generations beyond ours, and that he little needs our paltry defence, we believe that the greater part of functional (rather than theoretical) general practice is happy to acknowledge its hourly debt to Isaac Newton.

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Poor performance

Professor Pringle perpetrates two unproven allegations in this article within one sentence (November *BJGP*, page 876). Both need to be challenged.

First he says that, 'good communication skills and empathy can mask clinical incompetence.' This is probably true but ask the medical defence organisations whether they are more likely to have to defend a doctor who is technically poor but a good communicator, or a brusque, uncommunicative, if (usually) technically perfect doctor, and I suspect they will have more problems with the latter type. That said, 'you cannot fool all of the people all of the time' ...but I bet a good communicator can keep the act going for longer!

Secondly, he states that 'there are assumptions that poor clinical performers are high referrers to compensate for their weaknesses.' There are many potentially false presuppositions in this sentence. Is there any evidence that poor performers realise their weaknesses? If not, how can they be in any position take any sort of action to correct them, by referral or otherwise? Is there evidence that high referral rates are associated with poor performance? Maybe high referrers know a good deal of medicine and so pick up more problems. If this is happening then it represents good medicine. Conversely, are low referrers missing problems and so not referring enough?

Until more is known about the sensitivity and specificity of an individual GP's referral pattern, referral rates are no guide to the quality of individual GPs. To link high referral rates and poor performance in one sentence is currently dangerously misleading.

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