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**July – August 2007**



<b>ACCESS TO CARE.....</b>	<b>3</b>
<b>CHRONIC ILLNESS .....</b>	<b>8</b>
<b>HEALTH ECONOMICS .....</b>	<b>17</b>
<b>HEALTH INEQUALITIES .....</b>	<b>20</b>
<b>INFORMATION AND COMMUNICATION TECHNOLOGIES FOR HEALTH .....</b>	<b>22</b>
<b>MEDICINES MANAGEMENT .....</b>	<b>24</b>
<b>MENTAL HEALTH.....</b>	<b>28</b>
<b>NEED AND DEMAND FOR CARE .....</b>	<b>34</b>
<b>ORGANIZATIONS .....</b>	<b>36</b>
<b>PATIENT AND PUBLIC INVOLVEMENT .....</b>	<b>37</b>
<b>PRIMARY/SECONDARY CARE INTERFACE .....</b>	<b>40</b>
<b>QUALITY OF CARE .....</b>	<b>43</b>
<b>RESEARCH AND DEVELOPMENT .....</b>	<b>49</b>
<b>RESEARCH GOVERNANCE .....</b>	<b>53</b>
<b>RESEARCH METHODS .....</b>	<b>53</b>
<b>SERVICE ORGANISATION AND DELIVERY .....</b>	<b>56</b>
<b>WORKFORCE .....</b>	<b>59</b>

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## ACCESS TO CARE

**Gill N, Freeman G K. Continuity of care and rapid access: the potential impact of appointment systems. *Primary Health Care Research and Development* 2007;8 (3):235-42. DOI: 10.1017/S146342360700028X,**

In recent years government emphasis on improving access times in general practice has centred on a target of 48-hour access to a doctor. Attempts to achieve this by changing appointment systems may threaten relationship continuity of care, another valued feature of general practice. Now the recent primary care White Paper proposes financial incentives for both these aspects of care. We studied two contrasting booking systems in three large inner London group practices using a one page questionnaire distributed to consecutive patients in the waiting rooms. While most patients in the so-called 'advanced access' practice were seen very quickly, fewer patients, especially those with chronic conditions, were able to see their chosen doctor than in two practices offering more scope for booking appointments ahead. This preliminary study in an inner-city area supports other work, as well as anecdotal reports, suggesting that unbalanced emphasis on rapid access may impair patients' scope to see their practitioner of choice.

**Garratt AM, Danielsen K, Hunskaar S. Patient satisfaction questionnaires for primary care out-of-hours services: a systematic review. *British Journal of General Practice* 2007;57 (542):741-7.**

Background: Patient satisfaction questionnaires are increasingly used for assessing quality of care. AIM: To review the evidence for the reliability and validity of patient satisfaction questionnaires for out-of-hours care. Design: Systematic review. Setting: Primary care out-of-hours services. Method: Searches of CINAHL, EMBASE, MEDLINE((R)) and PsycINFO using terms relevant to the measurement of patient satisfaction and out-of-hours services. Abstracts were reviewed and information relating to questionnaire content, data quality, reliability, and validity were extracted from articles by two independent researchers. Results: Four questionnaires were found, two from the UK - the Patient Satisfaction with Out-of-Hours Care (PSOC) and Short Questionnaire for Out-of-Hours Care (SQOC) - and two from the Netherlands - the van Uden and Moll van Charante questionnaires. Questionnaire content was based on literature reviews and expert opinion; the PSOC and Moll van Charante questionnaires were also developed following interviews or focus groups with patients. Cronbach's alpha values were below 0.7 for some scales within the PSOC and van Uden questionnaires. Test-retest reliability was reported for the PSOC and Moll van Charante questionnaires. Tests of validity were few and did not give explicit consideration to the size of expected associations.

Conclusion: Potential users wishing to assess patient satisfaction should carefully consider the content of the questionnaires and its relevance to the application and patient group. The four questionnaires have limitations relating to their development and evaluation. The PSOC and van Uden questionnaires have low levels of reliability for some scales, which should be used with caution in future surveys

**Hopp FP,et al The use of telehealth for diabetes management: a qualitative study of telehealth provider perceptions. *Implementation Science* . 2007 ;2:14. DOI 10.1186/1748-5908-2-14**

Abstract: Background: Monitoring and Messaging Devices (MMDs) are telehealth systems used by patients in their homes, and are designed to promote patient self-management, patient education, and clinical monitoring and follow-up activities. Although these systems have been widely promoted by health care systems, including the Veterans Health Administration, very little information is available on factors that facilitate use of the MMD system, or on barriers to use. Methods: We conducted in-depth qualitative interviews with clinicians using MMD-based telehealth programs at two Veterans Affairs Medical Centers in the Midwestern United States. Results: Findings suggest that MMD program enrollment is limited by both clinical and non-clinical factors, and that patients have varying levels of program participation and system use. Telehealth providers see MMDs as a useful tool for monitoring patients who are interested in working on management of their disease, but are concerned with technical challenges and the time commitment required to use MMDs. Conclusion: Telehealth includes a rapidly evolving and potentially promising range of technologies for meeting the growing number of patients and clinicians who face the challenges of diabetes care, and future research should explore the most effective means of ensuring successful program implementation

**Miller EA. Solving the disjuncture between research and practice: Telehealth trends in the 21st century. *Health Policy* 2007;82 (2) :133-41. DOI: 10.1016/j.healthpol.2006.09.011**

Abstract: Despite the great promise that telehealth holds for improving cost, quality and access, there is currently a disjunction between what we know about telehealth and system growth and performance. To better understand the relationship between these two facets of telehealth development, this paper examines trends in telehealth, both as an intellectual endeavor and as a practical means of providing health services. Although there are promising avenues for government intervention in the way of coordination, funding, and regulatory practice, lack of knowledge regarding what works and what does not work has served as a major impediment to further progress in this area. In the absence of solid empirical evidence, key decision makers entertain doubts about telehealth's effectiveness, which, in turn, limits public leadership, private investment, and the long-term integration of telehealth into the health and technological mainstream. Solving the

disjuncture between research and practice will require additional clinical trials and evaluation studies that examine the efficacy of various technologies, both relative to each other and to conventional in person medical encounters. At the same time, it will require more even distribution of research across applications, service locations, regions, and nations. But the generation of additional high-quality empirical data on process, benefits, costs, and effects is only the beginning. That data must in turn be used to effectuate change. This will require researchers to take a more proactive stance in promoting use of their findings, both instrumentally, to adjust, modify or improve particular programs or policies, and conceptually, to influence how key stakeholders think about telehealth more generally

**Pilote L, et al. Socioeconomic Status, Access to Health Care, and Outcomes After Acute Myocardial Infarction in Canada's Universal Health Care System. *Medical Care* 2007;45 (7) :638-46. DOI: 10.1097/MLR.0b013e3180536779**

: Background:: There is a debate as to whether universal drug coverage confers similar access to care at all socioeconomic status (SES) levels. Experiences in Canada may bring light to questions raised regarding access. Objective:: To assess associations between SES and access to cardiac care and outcomes in Canada's universal health care system. Design, setting, and patients:: All patients admitted to acute care hospitals in Quebec (QC), Ontario (ON), and British Columbia (BC), between 1996 and either 2000 (QC) or 2001 (ON, BC) with acute myocardial infarction, were identified using provincial government administrative databases (n = 145,882). Measurements:: Variables representing SES grouped at the census area level were examined in association with use of cardiac medications and procedures, survival, and readmission, while adjusting for individual-level variables. A Bayesian hierarchical logistic regression model was used to account for the nested structure of the data. Results:: Despite provincial variations in SES and drug reimbursement policies, there were generally no associations between the SES variables and access to cardiac medications or invasive cardiac procedures. The few exceptions were not consistent across SES indicators and/or provinces. Similarly, the only observed effect of SES on clinical outcomes was in BC, where there was increased 1-year mortality among patients living in less-affluent regions (adjusted odds ratios per standard deviation change in proportion of low-income households, 95% Bayesian credible intervals, QC: 1.09, 0.96-1.25; ON: 1.02, 0.95-1.08; and BC: 1.18, 1.09-1.28). Conclusions:: These results suggest that intermediary factors other than SES, such as cardiovascular risk factors, likely account for observed "wealth-health" gradients in Canada. Implementation of a universal drug coverage policy could decrease socioeconomic disparities in access to health care

**Potter S, et al. Referral patterns, cancer diagnoses, and waiting times after introduction of two week wait rule for breast cancer: prospective cohort study. *British Medical Journal* 2007; 335 (7614):288. (11 August 2007) DOI: :10.1136/bmj.39258.688553.55**

Objective: To investigate the long term impact of the two week wait rule for breast cancer on referral patterns, cancer diagnoses, and waiting times. Design: Prospective

cohort study. Setting: A specialist breast clinic in a teaching hospital in Bristol. ParticipantS: All patients referred to breast clinic from primary care between 1999 and 2005. Main outcome measures: Number, route, and outcome of referrals from primary care and waiting times for urgent and routine appointments. Results: The annual number of referrals increased by 9% over the seven years from 3499 in 1999 to 3821 in 2005. Routine referrals decreased by 24% (from 1748 to 1331), but two week wait referrals increased by 42% (from 1751 to 2490) during this time. The percentage of patients diagnosed with cancer in the two week wait group decreased from 12.8% (224/1751) in 1999 to 7.7% (191/2490) in 2005 ( $P<0.001$ ), while the number of cancers detected in the "routine" group increased from 2.5% (43/1748) to 5.3% (70/1331) ( $P<0.001$ ) over the same period. About 27% (70/261) of people with cancer are currently referred in the non-urgent group. Waiting times for routine referrals have increased with time. Conclusion: The two week wait rule for breast cancer is failing patients. The number of cancers detected in the two week wait population is decreasing, and an unacceptable proportion is now being referred via the routine route. If breast cancer services are to be improved, the two week wait rule should be reviewed urgently

**Propper C et al Impact of patients' socioeconomic status on the distance travelled for hospital admission in the English National Health Service. *Journal of Health Services Research and Policy* 2007;12 (3) :153-9. DOI: 10.1258/135581907781543049**

Objectives: To compare the distances travelled for inpatient treatment in England between electoral wards prior to the introduction of a policy to extend patient choice and to consider the impact of patients' socio-economic status. Methods: Using Hospital Episode Statistics for 2003-04, the distance from a patient's residence to a National Health Service hospital was calculated for each admission. Distances were summed to electoral ward level to give the distribution of distances travelled at ward level. These were analysed to show the distance travelled for different admission types, ages of patient, rural/urban location, and the socioeconomic deprivation of the population of the ward. Results: There is considerable variation in the distances travelled for hospital admission between electoral wards. Some of this is explained by geographical location: individuals living in more rural areas travel further for elective (median 27.2 versus 15.0 km), emergency (25.3 versus 13.9 km) and maternity (25.0 versus 13.9 km) admissions. But individuals located in highly deprived wards travel less far, and this shorter distance is not explained simply by the closer location of hospitals to these wards. Conclusions: Before the introduction of more patient choice, there were considerable differences between individuals in the distances they travelled for hospital care. An increase in patient choice may disproportionately benefit people from less deprived areas

**Salisbury C, et al. Impact of Advanced Access on access, workload, and continuity: controlled before-and-after and simulated-patient study. *British Journal of General Practice* 2007;57 (541) :608-14.**

Background: Case studies from the US suggest that Advanced Access appointment systems lead to shorter delays for appointments, reduced workload, and increased continuity of care. AIM: To determine whether implementation of Advanced Access in

general practice is associated with the above benefits in the UK. Design of study: Controlled before-and-after and simulated-patient study. Setting: Twenty-four practices that had implemented Advanced Access and 24 that had not. Method: Anonymous telephone calls were made monthly to request an appointment. Numbers of appointments and patients consulting were calculated from practice records. Continuity was determined from anonymised patient records. Results: The wait for an appointment with any doctor was slightly shorter at Advanced Access practices than control practices (mean 1.00 day and 1.87 days respectively, adjusted difference -0.75; 95% confidence interval [CI] = -1.51 to 0.004 days). Advanced Access practices met the NHS Plan 48-hour access target on 71% of occasions and control practices on 60% of occasions (adjusted odds ratio 1.61; 95% CI = 0.78 to 3.31; P = 0.200). The number of appointments offered, and patients seen, increased at both Advanced Access and control practices over the period studied, with no evidence of differences between them. There was no difference between Advanced Access and control practices in continuity of care (adjusted difference 0.003; 95% CI = -0.07 to 0.07). Conclusion: Advanced Access practices provided slightly shorter waits for an appointment compared with control practices, but performance against NHS access targets was considerably poorer than officially reported for both types of practice. Advanced Access practices did not have reduced workload or increased continuity of care

**Salisbury C, Goodall S, Montgomery AA, Pickin DM, Edwards S, Sampson F *et al*. Does Advanced Access improve access to primary health care? Questionnaire survey of patients. *British Journal of General Practice* 2007;57 (541) :615-21.**

Background: General practices in England have been encouraged to introduce Advanced Access, but there is no robust evidence that this is associated with improved access in ways that matter to patients. AIM: To compare priorities and experiences of patients consulting in practices which do or do not operate Advanced Access. Design of study: Patient questionnaire survey. Setting: Forty-seven practices in 12 primary care trust areas of England. Method: Questionnaire administered when patients consulted. Results: Of 12,825 eligible patients, 10,821 (84%) responded. Most (70%) were consulting about a problem they had had for at least 'a few weeks'. Patients obtained their current appointment sooner in Advanced Access practices, but were less likely to have been able to book in advance. They could usually see a doctor more quickly than those in control practices, but were no more satisfied overall with the appointment system. The top priority for patients was to be seen on a day of choice rather than to be seen quickly, but different patient groups had different priorities. Patients in Advanced Access practices were no more or less likely to obtain an appointment that matched their priorities than those in control practices. Patients in both types of practice experienced problems making contact by telephone. Conclusion: Patients are seen more quickly in Advanced Access practices, but speed of access is less important to patients than choice of appointment; this may be because most consultations are about long-standing problems. Appointment systems need to be flexible to accommodate the different needs of different patient groups

## CHRONIC ILLNESS

**Calvert MJ, McManus RJ, Freemantle N. Management of type 2 diabetes with multiple oral hypoglycaemic agents or insulin in primary care: retrospective cohort study. *British Journal of General Practice* 2007;57 (539):455-60.**

Background: Intensive glycaemic control can reduce the risk of microvascular complications in people with type 2 diabetes. AIM: To examine the extent of monitoring and glycaemic control of patients with type 2 diabetes prescribed oral agents and/or insulin, and to investigate transition to insulin. Design of study: Retrospective cohort study. Setting: A total of 154 general practices in the UK contributing to the DIN-LINK database between 1995 and 2005. Method: People with type 2 diabetes were identified using Read codes and prescribing data. Outcome measures were: glycaemic monitoring and control on multiple oral agents and/or insulin, and transition to insulin. Results: A total of 14 824 people with type 2 diabetes were prescribed multiple oral agents concurrently, of whom 5064 (34.16%) had haemoglobin A(1c) (HbA(1c)) assessments 6 months before and following initiation of their last oral therapy. Mean HbA(1c) before therapy was 9.07%, which dropped to 8.16% following therapy (mean difference 0.91%, 95% confidence interval [CI] = 0.86 to 0.95, P <0.0001). Of the patients with HbA(1c) assessments, 3153 (62.26%) had evidence of poor glycaemic control following therapy. Median time to insulin for patients prescribed multiple oral agents was 7.7 years (95% CI = 7.4 to 8.5 years); 1513 people began insulin during the study and had HbA(1c) assessments 6 months before and following insulin. Mean HbA(1c) before insulin was 9.85% (standard deviation [SD] 1.96%) which decreased by 1.34%, (95% CI = 1.24% to 1.44%) following therapy, but 1110 people (73.36%) still had HbA(1c)  $\geq$ 7.5%. Conclusion: Many people with type 2 diabetes received inadequate monitoring and had poor glycaemic control. Intensive management is required to reduce the risk of microvascular complications

**Cannings-John R, *et al.* A case-control study of presentations in general practice before diagnosis of coeliac disease. *British Journal of General Practice* 2007;57 (541):636-42.**

Background: Delay in the diagnosis of coeliac disease prolongs morbidity and may increase mortality. Little is known about presentations in general practice that may predict a subsequent diagnosis of coeliac disease. Aim: To examine presentations in general practice during the 5 years prior to diagnosis of coeliac disease. Design of study: A case-control study with each biopsy-proven coeliac disease case matched by age, sex, and general practice to an average of two controls. SETTING: Thirty-seven general practices in south-east Wales. Method: Cases were identified via a secondary care clinic and controls recruited from the general practices of cases. General practice clinical records of both cases and controls were analysed to determine frequency of consultations, presenting symptoms, diagnoses, referrals, and investigations during the 5 years prior to diagnosis. Results: Cases (n = 68) had an increased number of consultations compared with controls (n = 160) during the 5 years prior to diagnosis (mean difference five

consultations,  $P = 0.001$ ). Three clinical features were independently associated with subsequent diagnosis of coeliac disease: depression and/or anxiety (odds ratio [OR] = 2.5, 95% confidence interval [CI] = 1.1 to 5.7,  $P = 0.031$ ); diarrhoea (OR = 4.5, 95% CI = 2.0 to 10.0,  $P < 0.001$ ); and anaemia (OR = 26.3, 95% CI = 5.7 to 120.6,  $P < 0.001$ ). Both diarrhoea and anaemia remained associated even when data for the year prior to diagnosis was excluded from the analysis. Conclusion: Further research is required to clarify the role of depression in the diagnosis of coeliac disease. GPs should consider testing for coeliac disease when patients present often, especially with diarrhoea and/or who are discovered to be anaemic. Further research is required to clarify the role of depression and/or anxiety in the diagnosis of coeliac disease

**Carey IM, et al. Spurious trends in coronary heart disease incidence: unintended consequences of the new GP contract? *British Journal of General Practice* 2007;57(539):486-9.**

Comparisons of the same patient data in 2004 and 2006 downloads of the DIN-LINK UK primary care database demonstrated unexpected differences in the rates of coronary heart disease between the datasets. Incidence rates were lower between 1996-2003 in the new (2006) download. Patient record checks demonstrated that coronary heart disease codes had been removed in the new download during the run-up to the new contract. Planners need to be aware of such issues when evaluating trends in CHD or other similar conditions

**Chow CK, et al Families of patients with premature coronary heart disease: an obvious but neglected target for primary prevention. *British Medical Journal* 8/9/2007; 335:7618 :481-5. DOI: 10.1136/bmj.39253.577859.BE**

First degree relatives of patients with premature coronary heart disease are at increased risk of the disease. Compared with the general population, siblings have at least double the risk, because of shared lifestyle risk factors and genetic predisposition. Offspring and partners are also at increased risk. Relatives have an increased prevalence of modifiable risk factors including hypertension, dyslipidaemia, and smoking. Some guidelines recommend screening of relatives, but surveys indicate that this does not occur in practice. We propose that first degree relatives of patients admitted for premature myocardial infarction should be identified and then offered screening and treatment for risk factors of coronary heart disease.

**Clements A, et al. The PSA testing dilemma: GPs' reports of consultations with asymptomatic men. A qualitative study. *BMC Family Practice* 2007;8:35 DOI: doi:10.1186/1471-2296-8-35**

**Background** The National Health Service Prostate Cancer Risk Management Programme (PCRMP) has recommended that screening for prostate cancer is available for asymptomatic men, on the understanding that they have been provided with full and balanced information about the advantages and limitations of the prostate-specific antigen (PSA) test. Guidance has been distributed to all GPs in England and Wales to assist in the provision of information to men. This study aimed to elicit GPs' accounts of their discussions with asymptomatic men who consult with concerns about prostate cancer, to identify the degree to which the PCRMP guidance was reflected in these consultations.

**Methods** Qualitative interview study. Semi-structured telephone interviews with 21 GPs from 18 GP practices in Oxfordshire.

**Results** All GPs reported undertaking some discussion with asymptomatic men about the PSA test. They described focussing most of the discussion on the false-positive and false-negative rates of the test, and the risks associated with a prostate biopsy. They reported less discussion of the potential for diagnosing indolent cancers, the dilemmas regarding treatment options for localised prostate cancer and the potential benefits of testing. Considerable variation existed between GPs in their accounts of the degree of detail given, and GP's presentation of information appeared to be affected by their personal views of the PSA test.

**Conclusion** The GPs in this study appear to recognise the importance of discussions regarding PSA testing; however, a full and balanced picture of the associated advantages and limitations does not seem to be consistently conveyed. Factors specific to PSA testing which appeared to have an impact on the GPs' discussions were the GP's personal opinions of the PSA test, and the need to counter men's primarily positive views of the benefits of PSA testing. Awareness of the impact of their views on the consultations may help GPs give men a more balanced presentation of the benefits and limitations of the PSA test.

**Dirkzwager AJE, Verhaak PFM. Patients with persistent medically unexplained symptoms in general practice: characteristics and quality of care. *BMC Family Practice* 31/5/ 2007 8:33 DOI: 10.1186/1471-2296-8-33**

**Background** Medically unexplained physical symptoms (MUPS) are common in general practice (GP), and are even more problematic as they become persistent. The present study examines the relationship between persistent MUPS in general practice on the one hand and quality of life, social conditions, and coping on the other hand. Additionally, it is examined how patients with persistent MUPS evaluate the quality of GP-care.

**Methods** Data were used from a representative survey of morbidity in Dutch general practice, in which data from the electronic medical records were extracted. A random sample of patients participated in an extensive health interview and completed self-reported measures on social isolation, coping and the quality of GP-care. Patients with persistent MUPS (N = 192) were compared with general practice patients not meeting the criteria for persistent MUPS (N = 7.314), and with a group of patients that visited the GP in comparable rates for medical diagnoses (N = 2.265). Multiple logistic regression analyses were used to control for relevant socio-demographic variables and chronic diseases.

**Results** After adjustment for demographics and chronic diseases, patients with persistent MUPS reported more psychological distress, more functional impairment, more social isolation, and they evaluated the quality of GP-care less positive than the other two patient groups. Although the majority of MUPS patients were positive about the quality of GP-care, they more often felt that they were not taken seriously or not

involved in treatment decisions, and more often reported that the GP did not take sufficient time. The three groups did not differ with respect to the statement that the GP unnecessarily explains physical problems as psychological ones. Conclusion Strengthening MUPS patients' social network and encouraging social activities may be a meaningful intervention in which the GP may play a stimulating role. To further improve MUPS patients' satisfaction with GP-care, GPs may pay extra attention to taking sufficient time when treating MUPS patients, taking the problems seriously, and involving them in treatment decisions.

**Eborall H,et al Patients' experiences of screening for type 2 diabetes: prospective qualitative study embedded in the ADDITION (Cambridge) randomised controlled trial. *British Medical Journal* 8/9/2007; 335:7618 :490 - DOI: 10.1136/bmj.39308.392176.BE**

Objectives: To provide insight into factors that contribute to the anxiety reported in a quantitative study of the psychological effect of screening for type 2 diabetes. To explore expectations of and reactions to the screening experience of patients with positive, negative, and intermediate results. Design: Prospective qualitative interview study of patients attending a screening programme for type 2 diabetes. Setting: Seven general practices in the ADDITION (Cambridge) trial in the east of England. Participants: 23 participants (aged 50-69) attending different stages in the screening process. Results: participants' perceptions changed as they progressed through the screening programme; the stepwise process seemed to help them adjust psychologically. The first screening test was typically considered unimportant and was attended with no thought about its implications. By the final diagnostic test, type 2 diabetes was considered a strong possibility, albeit a "mild" form. After diagnosis, people with screen detected type 2 diabetes tended to downplay its importance and talked confidently about their plans to control it. Participants with intermediate results seemed uncertain about their diagnosis, and those who screened negative were largely unaware of their remaining high risk. Conclusions: This study helps in understanding the limited psychological impact of screening for type 2 diabetes quantified previously, in particular by the quantitative substudy of ADDITION (Cambridge). The findings have implications for implementing such a screening programme in terms of timing and content

**Eborall HC, et al Psychological impact of screening for type 2 diabetes: controlled trial and comparative study embedded in the ADDITION (Cambridge) randomised controlled trial. *British Medical Journal* 8/9/2007 ;335:7618 :486 -.**

Objective: to quantify the psychological impact of primary care based stepwise screening for type 2 diabetes. Design: Controlled trial and comparative study embedded in a randomised controlled trial. Setting: 15 practices (10 screening, five control) in the ADDITION (Cambridge) trial in the east of England. Participants: 7380 adults (aged 40-69) in the top fourth for risk of having undiagnosed type 2 diabetes (6416 invited for screening, 964 controls). Interventions: Invited for screening for type 2 diabetes or not invited (controls), incorporating a comparative study of subgroups of screening attenders.

Attendees completed questionnaires after a random blood glucose test and at 3-6 months and 12-15 months later. Controls were sent questionnaires at corresponding time points. Non-attendees were sent questionnaires at 3-6 months and 12-15 months. Main outcome measures: State anxiety (Spielberger state anxiety inventory), anxiety and depression (hospital anxiety and depression scale), worry about diabetes, and self rated health. Results: No significant differences were found between the screening and control participants at any time-for example, difference in means (95% confidence intervals) for state anxiety after the initial blood glucose test was -0.53, -2.60 to 1.54, at 3-6 months was 1.51 (-0.17 to 3.20), and at 12-15 months was 0.57, -1.11 to 2.24. After the initial test, compared with participants who screened negative, those who screened positive reported significantly poorer general health (difference in means -0.19, -0.25 to -0.13), higher state anxiety (0.93, -0.02 to 1.88), higher depression (0.32, 0.08 to 0.56), and higher worry about diabetes (0.25, 0.09 to 0.41), although effect sizes were small. Small but significant trends were found for self rated health across the screening subgroups at 3-6 months (P=0.047) and for worry about diabetes across the screen negative groups at 3-6 months and 12-15 months (P=0.001). Conclusions: Screening for type 2 diabetes has limited psychological impact on patients. Implementing a national screening programme based on the stepwise screening procedure used in the ADDITION (Cambridge) trial is unlikely to have significant consequences for patients' psychological health. TRIAL REGISTRATION: Current Controlled Trials ISRCTN99175498 [controlled-trials.com]

**Haussler B, Fischer GC, Meyer S, Sturm D. Risk assessment in diabetes management: how do general practitioners estimate risks due to diabetes? *Quality and Safety in Health Care* 2007;16 (3) :208-12. DOI: 10.1136/qshc.2006.019539**

Objectives: To evaluate the ability of general practitioners (GPs) in Germany to estimate the risk of patients with diabetes developing complications. Methods: An interview study using a structured questionnaire to estimate risks of four case vignettes having diabetes-specific complications within the next 10 years, risk reduction and life expectancy potential. A representative random sample of 584 GPs has been drawn, of which 150 could be interviewed. We compared GPs' estimates among each other (intraclass correlation coefficient (ICC) and Cohen's (multirater-) kappa) and with risks for long-term complications generated by the multifactor disease model "Mellibase", which is a knowledge-based support system for medical decision management. Results: The risk estimates by GPs varied widely (ICC 0.21 95% CI (0.13 to 0.36)). The average level of potential risk reduction was between 47% and 70%. Compared with Mellibase values, on average, the GPs overestimated the risk threefold. Mean estimates of potential prolongation of life expectancy were close to 10 years for each patient, whereas the Mellibase calculations ranged from 3 to 10 years. Conclusions: Overestimation could lead to unnecessary care and waste of resources

**Kenter EG, Okkes IM, Oskam SK, Lamberts H. Once tired, always tired: limitations in function over time of tired patients in Dutch general practice. *European Journal of General Practice* 2007;13 (2):67-74.**

Abstract: Objective: To gain insight into limitations in function over time of general-practice patients who presented and were diagnosed with "tiredness". Methods: In a routine family-practice electronic register based on use of the International Classification of Primary Care (ICPC), 684 patients were identified who presented (in 1997 or 1998) with the complaint tiredness, who were given the same symptom diagnosis, and who still had this diagnosis on 1 August 1999. A questionnaire (WONCA/COOP charts, HAD Scale, recent medical care, tiredness and attribution) was sent to these 684 "cases" and 858 controls. In a logistic regression analysis (16 dichotomous variables), we constructed five models for optimizing sensitivity and specificity for the detection of patients with an episode of care for "tiredness". Results: We received 385 fully completed questionnaires of cases, on average 19.7-31.7 months after the start of their episode of care for "tiredness". The results of the 1997 and 1998 cases were similar. Cases did considerably worse than did the 385 optimally matched controls: e.g., seriously limited by tiredness: 52% of cases vs 32% of controls; poor overall health: 35% of cases vs 20% of controls; HAD Scale scores indicating anxiety or depression: about 20% of cases vs about 10% of controls. Highest sensitivity (70%) was reached by including poor overall health, recent medical care and HAD Scale depression score >10 in the model; and highest specificity (65%) by including poor overall health and a HAD Scale anxiety score >7. Conclusion: Patients who present with tiredness and receive the same diagnosis have a high probability of suffering from substantial limitations in function in the years following diagnosis. Their limitations are more serious than those of controls, but no indication is found for a specific limitation. The indicators are strongly related and concentrate around "poor overall health"

**Keogh K M, et al. Changing illness perceptions in patients with poorly controlled type 2 diabetes, a randomised controlled trial of a family-based intervention: protocol and pilot study. *BMC Family Practice* 2007 8:36 DOI: doi:10.1186/1471-2296-8-36**

Background This paper presents the pilot study and protocol for a randomised controlled trial to test the effectiveness of a psychological, family-based intervention to improve outcomes in those with poorly controlled type 2 diabetes. The intervention has been designed to change the illness perceptions of patients with poorly controlled type 2 diabetes, and their family members. It is a complex psychological intervention, developed from the Self-Regulatory Model of Illness Behaviour. The important influence the family context can have in psychological interventions and diabetes management is also recognised, by the inclusion of patients' family members. Methods We aim to recruit 122 patients with persistently poorly controlled diabetes. Patients are deemed to have persistent poor control when at least two out of their last three HbA1c readings are 8.0% or over. Patients nominate a family member to participate with them, and this patient/family member dyad is randomly allocated to either the intervention or control group. Participants in the control group receive their usual care. Participants in the intervention group participate, with their family members, in three intervention sessions. Sessions one and two are delivered in the participant's home by a health psychologist.

Session one takes place approximately one week after session two, with the third session, a follow-up telephone call, one week later. The intervention is based upon clarifying the illness perceptions of both the patient and the family member, examining how they influence self-management behaviours, improving the degree of similarity of patient and family member perceptions in a positive direction and developing personalized action plans to improve diabetes management. Discussion This study is the first of its kind to incorporate the evidence from illness perceptions research into developing and applying an intervention for people with poorly controlled diabetes and their families. This study also acknowledges the important role of family members in effective diabetes care. ISRCTN62219234

**Mallen CD, et al Prognostic factors for musculoskeletal pain in primary care: a systematic review. *British Journal of General Practice* 2007; 57 (541) :655-61.**

Background: Estimating the future course of musculoskeletal pain is an important consideration in the primary care consultation for patients and healthcare professionals. Studies of prognostic indicators tend to have been viewed in relation to each site separately, however, an alternative view is that some prognostic indicators may be common across different sites of musculoskeletal pain. Aim: To identify generic prognostic indicators for patients with musculoskeletal pain in primary care. Design of study: Systematic review. Setting: Observational cohort studies in primary care. Method: MEDLINE, EMBASE, PsychINFO and CINAHL electronic databases were searched from inception to April 2006. Inclusion criteria were that the study was a primary care-based cohort, published in English and contained information on prognostic indicators for musculoskeletal conditions. Results: Forty-five studies were included. Eleven factors, assessed at baseline, were found to be associated with poor outcome at follow up for at least two different regional pain complaints: higher pain severity at baseline, longer pain duration, multiple-site pain, previous pain episodes, anxiety and/or depression, higher somatic perceptions and/or distress, adverse coping strategies, low social support, older age, higher baseline disability, and greater movement restriction. Conclusion: Despite substantial heterogeneity in the design and analysis of original studies, this review has identified potential generic prognostic indicators that may be useful when assessing any regional musculoskeletal pain complaint. However, Its unclear whether these indicators, used alone, or in combination, can correctly estimate the likely course of individual patients' problems. Further research is needed, particularly in peripheral joint pain and using assessment methods feasible for routine practice

**Newbould J, Taylor D, Bury M. Lay-led self-management in chronic illness: a review of the evidence. *Chronic Illness* . 2006; 2 (4) :249-61. DOI: 10.1179/174592006X157508**

**Objectives:** In this paper, we seek to clarify what is known about self-care in chronic illness and the impact of lay-led self-management programmes. The main focus of the paper is the specific 'lay-led' interventions developed by Kate Lorig and her collaborators in the USA, and in the context of the English Expert Patients Programme (EPP). **Methods:** A systematic search of relevant databases was undertaken. **Results:** Seventeen articles and two conference papers met the criteria set. These papers documented the use of condition-specific lay-led self-management programmes and generic lay-led self-management programmes. **Discussion:** Despite the potential benefits of enhanced self-management, the review of the literature presented here suggests several possible problems associated with the presentation and implementation of initiatives such as the EPP programme. These include the possibility that advocates of public service improvements have on occasion been tempted to overstate the evidence for the relative and absolute effectiveness of lay-led self-management programmes. In addition, the varied experiences of those living with a chronic illness warn against promulgating rigid prescriptions about what patients -should think and do. The evidence to date is indicative of short-term benefits being derived from the provision of lay-led self-management programmes

**Perria C, et al. Implementing a guideline for the treatment of type 2 diabetics: results of a cluster-randomized controlled trial (C-RCT). *BMC Health Services Research* 2007; 7:79. DOI: 10.1186/1472-6963-7-79**

**Background:** In Italy many diabetics still lack adequate care in general practice. We assessed the effectiveness of different strategies for the implementation of an evidence-based guideline for the management of non-complicated type 2 diabetes among General Practitioners (GPs) of Lazio region. **MethodS:** Three-arm cluster-randomised controlled trial with GPs as units of randomisation (clusters). 252 GPs were randomised either to an active strategy (training module with administration of the guideline), or to a passive dissemination (administration of the guideline only), or to usual care (control). Data on prescriptions of tests and drugs were collected by existing information systems, whereas patients' data came from GPs' databases. Process outcomes were measured at the cluster level one year after the intervention. Primary outcomes concerned the measurement of glycosilated haemoglobin and the commissioning of micro- and macrovascular complications assessment tests. In order to assess the physicians' drug prescribing behaviour secondary outcomes were also calculated. **ResultS:** GPs identified 6395 uncomplicated type 2 patients with a high prevalence of cardiovascular risk factors. Data on GPs baseline performance show low proportions of glycosilated haemoglobin assessments. Results of the C-RCT analysis indicate that the active implementation strategy was ineffective relating to all primary outcomes (respectively, OR 1.06 [95% IC:

0.76-1.46]; OR 1.07 [95% IC: 0.80-1.43]; OR 1.4 [95% IC:0.91-2.16]. Similarly, passive dissemination of the guideline showed no effect. Conclusion: In our region compliance of GPs with guidelines was not enhanced by a structured learning programme. Implementation through organizational measures appears to be essential to induce behavioural changes. Trial registration: ISRCTN80116232

**Rogers A. Damned by faint praise? *Chronic Illness* . 2006; 2: (4) 262-4. DOI: 10.1177/17423953060020040501**

Jennifer Newbould, David Taylor and Mike Bury have provided an analytically sophisticated and fine-grained review of the available evidence about lay-led self-management in chronic illness.<sup>1</sup> They pay meticulous attention to methods, concepts, processes and outcomes. My intention in this short commentary is to focus on and discuss selected issues raised by their article. New findings from research are emerging all the time, and any review is necessarily contingent. This is particularly the case in the rapidly changing policy context of self-management and chronic illness.

**Tahrani AA, et al. Diabetes care and the new GMS contract: the evidence for a whole county. *British Journal of General Practice* 2007; 57 :539 483-5.**

Abstract: The aim of this study was to assess the impact of the Quality and Outcomes Framework (QOF) of the new GP contract on diabetes care in Shropshire, which has a total population of approximately 460 000. The mean percentage of patients achieving each of the quality indicators in each practice in Shropshire, before and after the implementation of the QOF was calculated. All 16 867 patients with diabetes from all 66 Shropshire practices were included. There were significant improvements in the percentage of patients achieving targets for all quality indicators between April 2004 to March 2006 (P<0.001)

**Winters CA, et al The rural context and women's self-management of chronic health conditions. *Chronic Illness* 2006;2 (4) 273-89. DOI: 10.1179/174592006X157517**

Objective: To examine the rural context and describe its influence on the self-management of chronic illness by women living in a rural setting. Methods: The Women to Women (WTW) project is a research-based computer intervention that provides health education and peer support to rural women with chronic health conditions. Messages posted to the online support and health education chat rooms were examined to determine the characteristics of the rural context in relation to the women's illness self-management. Results: 'Distance' was the overarching characteristic of the rural context that influenced the women's ability to self-manage their chronic health problems. The effect of distance was woven throughout each of the four predominant themes that emerged from the data as having influence - physical setting, social/cultural/economic environment, nature of

women's work, and accessibility/quality of healthcare. These influences affected the women's self-management abilities both negatively and positively. Discussion: The rural context profoundly influenced the ability of rural women to self-manage their chronic conditions. From the data, health professionals and policy-makers can glean information about the barriers to healthcare faced by rural women who are trying to manage their chronic health problems in comparative isolation

## HEALTH ECONOMICS

**Box, G** In search of quality in practice based commissioning *Quality in Primary Care* 2007 15 (4) 235-240

Practice-based commissioning is the mechanism whereby groups or clusters of practices in England are given indicative budgets to purchase health care for the needs of their patient populations. This article describes people-based commissioning, to be distinguished from the more technical and short-term approach characterised as pocket book commissioning, and argues that people-based commissioning should be the preferred approach, which needs to address public health and mental health needs of the community, be based on a clear ethical framework and seek political support through real engagement with the public.

**Brekke KR, Sorgard L.** Public versus private health care in a national health service. *Health Economics* 2007; 16 (6): 579-601. DOI: 10.1002/hec.1185

This paper studies the interaction between public and private health care provision in a National Health Service (NHS), with free public care and costly private care. The health authority decides whether or not to allow private provision and sets the public sector remuneration. The physicians allocate their time (effort) in the public and (if allowed) in the private sector based on the public wage income and the private sector profits. We show that allowing physician dual practice 'crowds out' public provision, and results in lower overall health care provision. While the health authority can mitigate this effect by offering a higher wage, we find that a ban on dual practice is more efficient if private sector competition is weak and public and private care are sufficiently close substitutes. On the other hand, if private sector competition is sufficiently tough, a mixed system, with physician dual practice, is always preferable to a pure NHS system

**McDonald R, et al.** Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study. *British Medical Journal* June 30<sup>th</sup> 2007 334(7608):1357.. epub ahead of publication DOI: doi:10.1136/bmj.39238.890810.BE

Objective To explore the impact of financial incentives for quality of care on practice organisation, clinical autonomy, and internal motivation of doctors and nurses working in primary care. Design Ethnographic case study. Setting Two English general practices.

Participants 12 general practitioners, nine nurses, four healthcare assistants, and four administrative staff. Main outcome measure Observation of practices over a five month period after the introduction of financial incentives for quality of care introduced in the 2004 general practitioner contract. Results After the introduction of the quality and outcomes framework there was an increase in the use of templates to collect data on quality of care. New regimens of surveillance were adopted, with clinicians seen as "chasers" or the "chased," depending on their individual responsibility for delivering quality targets. Attitudes towards the contract were largely positive, although discontent was higher in the practice with a more intensive surveillance regimen. Nurses expressed more concern than doctors about changes to their clinical practice but also appreciated being given responsibility for delivering on targets in particular disease areas. Most doctors did not question the quality targets that existed at the time or the implications of the targets for their own clinical autonomy. Conclusions Implementation of financial incentives for quality of care did not seem to have damaged the internal motivation of the general practitioners studied, although more concern was expressed by nurses.

**Pearson, S, Littlejohns P** **Reallocating resources: how should the National Institute for Health and Clinical Excellence guide disinvestment efforts in the National Health Service** *Journal of Health Services Research and Policy* 2007 12 (3) 160-5 DOI: 10.1258/135581907781542987

The recent acute budgetary pressures within the English National Health Service (NHS) have accentuated calls for targeted disinvestment thereby eliminating ineffective or low-value services to provide resources that can be reallocated toward more cost-effective purposes. This challenge extends beyond allocating new resources wisely, a goal that has been, since its inception, the primary focus of the National Institute for Health and Clinical Excellence (NICE). But on 6 September 2006, the Department of Health announced a new mandate for NICE to help the NHS identify interventions that are not effective. This paper discusses current NICE efforts to support value in the NHS and then explores the policy options available to the Institute as it prepares to launch a programme to meet the NHS request for guidance on disinvestment. All of the possible options present challenges. NICE will need to collaborate in new ways with partners inside, and perhaps outside, the NHS. However, the Institute has an established reputation for rigour, transparency and political durability that makes it well qualified to sustain public support in the face of difficult decisions. Disinvestment will provide a stern test of these qualities

**Roberts TE, et al.** **Cost effectiveness of home based population screening for Chlamydia trachomatis in the UK: economic evaluation of chlamydia screening studies (ClASS) project.** *British Medical Journal* 11/8/ 2007; 335:291. DOI: 10.1136/bmj.39262.683345.AE

Objective: To investigate the cost effectiveness of screening for Chlamydia trachomatis compared with a policy of no organised screening in the United Kingdom. Design: economic evaluation using a transmission dynamic mathematical model. Setting: Central and southwest England. Participants: Hypothetical population of 50,000 men and women,

in which all those aged 16-24 years were invited to be screened each year. Main outcome measures: Cost effectiveness based on major outcomes averted, defined as pelvic inflammatory disease, ectopic pregnancy, infertility, or neonatal complications. Results: The incremental cost per major outcome averted for a programme of screening women only (assuming eight years of screening) was 22,300 pounds (33,000 euros; \$45,000) compared with no organised screening. For a programme screening both men and women, the incremental cost effectiveness ratio was approximately 28,900 pounds. Pelvic inflammatory disease leading to hospital admission was the most frequently averted major outcome. The model was highly sensitive to the incidence of major outcomes and to uptake of screening. When both were increased the cost effectiveness ratio fell to 6200 pound per major outcome averted for screening women only. Conclusions: Proactive register based screening for chlamydia is not cost effective if the uptake of screening and incidence of complications are based on contemporary empirical studies, which show lower rates than commonly assumed. These data are relevant to discussions about the cost effectiveness of the opportunistic model of chlamydia screening being introduced in England

**Steel N, et al Quality of clinical primary care and targeted incentive payments: an observational study. *British Journal of General Practice*. 2007; 57 (539) :449-54**

Background: Payments for recorded evidence of quality of clinical care in UK general practices were introduced in 2004. Aim: To examine the relationship between changes in recorded quality of care for four common chronic conditions from, 2003 to 2005, and the payment of incentives. Design of study: Retrospective observational study comparing incentivised and non-incentivised indicators of quality of care. Setting: Eighteen general practices in England. Method: Medical records were examined for 1156 patients. The percentage of eligible quality indicators achieved for each patient was assessed in 2003 and 2005. Twenty-one quality indicators referred to asthma and hypertension: six subject to and 15 not subject to incentive payments. Another 15 indicators referred to depression and osteoarthritis which were not subject to incentive payments. Results: A significant increase occurred for the six indicators linked to incentive payments: from 75% achieved in 2003 to 91% in 2005 (change = 16%, 95% confidence interval [CI] = 10 to 22%,  $P < 0.01$ ). A significant increase also occurred for 15 other indicators linked to 'incentivised conditions'; 53 to 64% (change = 11%, 95% CI = 6 to 15%,  $P < 0.01$ ). The 'non-incentivised conditions' started at a lower achievement level, and did not increase significantly: 35 to 36% (change = 2%, 95% CI = -1 to 4%,  $P = 0.19$ ). Conclusion: The introduction of financial incentives was associated with substantial apparent quality improvement for incentivised conditions. For non-incentivised conditions, quality did not appear to improve. Patients with non-incentivised conditions may be at risk of poorer quality care

**VanGeest J, et al Impact of managed care on physicians' decisions to manipulate reimbursement rules: an explanatory model. *Journal of Health Services Research and Policy* 2007;12: (3) 147-52. DOI: 10.1258/135581907781543102**

Objective: To develop and test an explanatory model of the impact of managed care on physicians' decisions to manipulate reimbursement rules for patients. Methods: A self-administered mailed questionnaire of a national random sample of 1124 practicing physicians in the USA. Structural equation modelling was used. The main outcome measure assessed whether or not physicians had manipulated reimbursement rules (such as exaggerated the severity of patients conditions, changed billing diagnoses, or reported signs or symptoms that the patients did not have) to help patients secure coverage for needed treatment or services. Results: The response rate was 64% (n = 720). Physicians' decisions to manipulate reimbursement rules for patients are directly driven not only by ethical beliefs about gaming the system but also by requests from patients, the perception of insufficient time to deliver care, and the proportion of Medicaid patients. Covert advocacy is also the indirect result of utilization review hassles, primary care specialty, and practice environment. Conclusions: Managed care is not just a set of rules that physicians choose to follow or disobey, but an environment of competing pressures from patients, purchasers, and high workload. Reimbursement manipulation is a response to that environment, rather than simply a reflection of individual physicians' values

## **HEALTH INEQUALITIES**

**Beresford P. User involvement, research and health inequalities: developing new directions. *Health and Social Care in the Community* 2007;15: (4) 306-12. DOI: 10.1111/j.1365-2524.2007.00688.x**

Placed in the context of broader discussions and developments about service user involvement in research and evaluation, this paper looks at the role that user involvement research may play in health inequalities research. It examines the pressures for and against such user involvement research, its different expressions and ideological relations, and what particular contribution it may have to offer in researching health inequalities. In considering how it may help in developing substantive understandings of these issues and the role it may play in the future, particular attention is paid to the issue of enabling the diverse involvement of service users in order not to reinforce existing exclusions and barriers in research, policy and practice

**Coleman K, Hamblin R. Can Pay-for-Performance Improve Quality and Reduce Health Disparities? *PLoS.Med.* 2007; 4:e216. doi:10.1371/journal.pmed.0040216**

Pay-for-performance programs have been embraced by United States and United Kingdom policy makers and payors (those who pay for health-care services) as a means to improve the quality of health care. In fact, since the Institute of Medicine's 2001 report *Crossing the Quality Chasm* suggested realigning incentives to improve care [1], the UK's National Health Service (NHS) introduced pay-for-performance (P4P) contracts for all family practitioners. In the US, more than half of commercial health maintenance organizations have started using such contracts, and recent legislation requires that the Centers for Medicare and Medicaid Services do the same for Medicare [2].

**Millett C, et al. Ethnic Disparities in Diabetes Management and Pay-for-Performance in the UK: The Wandsworth Prospective Diabetes Study. *PLoS Medicine* 2007;4:e191. DOI: 10.1371/journal.pmed.0040191**

**Background** Pay-for-performance rewards health-care providers by paying them more if they succeed in meeting performance targets. A new contract for general practitioners in the United Kingdom represents the most radical shift towards pay-for-performance seen in any health-care system. The contract provides an important opportunity to address disparities in chronic disease management between ethnic and socioeconomic groups. We examined disparities in management of people with diabetes and intermediate clinical outcomes within a multiethnic population in primary care before and after the introduction of the new contract in April 2004. **Methods and Findings** We conducted a population-based longitudinal survey, using electronic general practice records, in an ethnically diverse part of southwest London. Outcome measures were prescribing levels and achievement of national treatment targets (HbA<sub>1c</sub> 7.0%; blood pressure [BP] < 140/80 mm Hg; total cholesterol 5 mmol/l or 193 mg/dl). The proportion of patients reaching treatment targets for HbA<sub>1c</sub>, BP, and total cholesterol increased significantly after the implementation of the new contract. The extents of these increases were broadly uniform across ethnic groups, with the exception of the black Caribbean patient group, which had a significantly lower improvement in HbA<sub>1c</sub> (adjusted odds ratio [AOR] 0.75, 95% confidence interval [CI] 0.57-0.97) and BP control (AOR 0.65, 95% CI 0.53-0.81) relative to the white British patient group. Variations in prescribing and achievement of treatment targets between ethnic groups present in 2003 were not attenuated in 2005. **Conclusions** Pay-for-performance incentives have not addressed disparities in the management and control of diabetes between ethnic groups. Quality improvement initiatives must place greater emphasis on minority communities to avoid continued disparities in mortality from cardiovascular disease and the other major complications of diabetes.

**Millett C, et al. Diabetes prevalence, process of care and outcomes in relation to practice size, caseload and deprivation: national cross sectional study in primary care. *Journal of the Royal Society of Medicine* 2007; 100 (6) :275-83. DOI: 10.1258/jrsm.100.6.275**

**Objective** To examine the association between practice list size, deprivation and the quality of care of patients with diabetes. **Design** Population-based cross-sectional study

using Quality and Outcomes Framework data. Setting England and Scotland. Participants 55 522 778 patients and 8970 general practices with 1 852 762 people with diabetes. Interventions None. Main outcome measures Seventeen process and surrogate outcome measures of diabetes care. Results The prevalence of diabetes was 3.3%. Prevalence differed with practice list size and deprivation: smaller and more deprived practices had a higher mean prevalence than larger and more affluent practices (3.8% versus 2.8%). Practices with large patient list sizes had the highest quality of care scores, even after stratifying for deprivation. However, with the exception of retinal screening, peripheral pulses and neuropathy testing, differences in achievement between small and large practices were modest (<5%). Small practices performed nearly as well as the largest practices in achievement of intermediate outcome targets for HbA1c, blood pressure and cholesterol (smallest versus largest practices: 57.4% versus 58.7%; 70.7% versus 70.7%; and 69.5% versus 72.7%, respectively). Deprivation had a negative effect on the achieved scores and this was more pronounced for smaller practices. Conclusion Our study provides some evidence of a volume-outcome association in the management of diabetes in primary care; this appears most pronounced in deprived areas.

## **INFORMATION AND COMMUNICATION TECHNOLOGIES FOR HEALTH**

**Hendy J, et al Implementing the NHS information technology programme: qualitative study of progress in acute trusts. *British Medical Journal* 30/6/2007; 334: 1360. DOI: 10.1136/bmj.39195.598461.551**

Objectives: To describe progress and perceived challenges in implementing the NHS information and technology (IT) programme in England. DESIGN: Case studies and in-depth interviews, with themes identified using a framework developed from grounded theory. We interviewed personnel who had been interviewed 18 months earlier, or new personnel in the same posts. Setting: Four NHS acute hospital trusts in England. Participants: Senior trust managers and clinicians, including chief executives, directors of IT, medical directors, and directors of nursing. Results: Interviewees unreservedly supported the goals of the programme but had several serious concerns. As before, implementation is hampered by local financial deficits, delays in implementing patient administration systems that are compliant with the programme, and poor communication between Connecting for Health (the agency responsible for the programme) and local managers. New issues were raised. Local managers cannot prioritise implementing the programme because of competing financial priorities and uncertainties about the programme. They perceive a growing risk to patients' safety associated with delays and a loss of integration of components of the programme, and are discontented with Choose and Book (electronic booking for referrals from primary care). Conclusions: We recommend that the programme sets realistic timetables for individual trusts and advises managers about interim IT systems they have to purchase because of delays outside their

control. Advice needs to be mindful of the need for trusts to ensure longer term compatibility with the programme and value for money. Trusts need assistance in prioritising modernisation of IT by, for example, including implementation of the programme in the performance management framework. Even with Connecting for Health adopting a different approach of setting central standards with local implementation, these issues will still need to be addressed. Lessons learnt in the NHS have wider relevance as healthcare systems, such as in France and Australia, look to realise the potential of large scale IT modernization

**Greggains B IT-enabled primary care: what quality gains might the NHS IT programme offer to patients? *Quality in Primary Care* 2007 15 (4) 229-234**

Much of the debate about the NHS IT programme has been around process not outcomes. At this stage of climbing the mountain of implementation, people's concerns understandably centre on costs, timing, security, resources, training, interoperability and process re-engineering. For the patient, though, there are wider quality issues about what quality gains an implemented system might deliver and what the vision of care might be. This paper examines diverse aspects of the NHS IT programme and discusses the patient benefits in primary care that may flow from the various initiatives. It evaluates which will be especially helpful and to whom. It also considers which initiatives at present seem in need of major development in order to realise the benefits for patients.

**Klein Woolthuis EP, *et al.* Identifying people at risk for undiagnosed type 2 diabetes using the GP's electronic medical record. *Family Practice* . 2007; 24 (3) :230-6.**

Background: Screening for type 2 diabetes is recommended in at-risk patients. The GP's electronic medical record (EMR) might be an attractive tool for identifying them. Objective: To assess the value of the GP's EMR in identifying patients at risk for undiagnosed type 2 diabetes and the feasibility to use this information in usual care to initiate screening. Methods: In 11 Dutch general practices (25 GPs), we performed an EMR-derived risk assessment in all patients aged > or =45 and < or =75 years, without known diabetes, identifying those at risk according to the American Diabetes Association recommendations. Patients with an EMR-derived risk or risk after additional risk assessment during regular consultation were invited for capillary fasting plasma glucose (FPG) measurement. Results: Of 13 581 patients, 3858 (28%) had an EMR-based risk (hypertension, cardiovascular disease, lipid metabolism disorders and/or obesity). Additional risk assessment in those without an EMR-based risk showed that in 51%, greater than one risk factor was present, mainly family history (51.2%) and obesity (59%). Ninety per cent returned for the FPG measurement. In both groups, we found patients with an FPG exceeding the cut point for diabetes (5.9% versus 4.1%). Conclusions: With additional risk assessment during consultation, the GP's EMR was valuable in identifying patients at risk for undiagnosed type 2 diabetes. It was feasible to use this information to initiate screening. At-risk patients were willing to take part in screening. Better registration of family history and obesity will improve the EMR as a tool for identifying at-risk patients in opportunistic screening in general practice

## MEDICINES MANAGEMENT

**Banks J, Shaw A, Weiss MC. The community pharmacy and discursive complexity: a qualitative study of interaction between counter assistants and customers. *Health and Social Care in the Community* 2007; 15 (4) :313-21. DOI: 10.1111/j.1365-2524.2007.00690.x**

The present paper examines the developing role of the medicines counter assistant (MCA) based in community pharmacies in the UK. In recent years, community pharmacies have been promoted as sources of primary care advice, and this has been accompanied by an increase in the number of pharmacy-only medicines made available for purchase without prescription. At the forefront of these changes is the MCA, who responds to requests for medicines and also advises customers seeking guidance on treating minor illness. This paper uses qualitative data drawn from non-participant observation of interactions between MCAs and customers in six community pharmacies in the south-west region of the UK. The data show communication in the pharmacy to be a complex process, characterised by multiple discourses including medical, retail and pharmaceutical information. At times, the different discourses worked in equilibrium, but there were also regular occurrences of clashes between the different discourses, where interaction became problematic. The authors argue that the current focus on pharmacy protocols to structure communication is, in some cases, too rigid for meaningful interaction and does not acknowledge the complexity of the encounter. A specific way forward for developing the interaction is discussed

**Blenkinsopp A et al Medicines in primary care: towards a patient-centred approach to quality *Quality in Primary Care* 2007 15 (4) 213-220**

Access to, and use of, medicines were key areas identified for improvement in *the NHS Plan* in 2000. In this discussion paper and in relation to the primary care setting we consider the problems that patients have in accessing and using medicines, review relevant initiatives in NHS policy and practice, and their effects and propose standards for patient-centred medicines management

**Chung, A et al. Effect of antibiotic prescribing on antibiotic resistance in individual children in primary care: prospective cohort study *British Medical Journal* 335 (7617) 429 – 431 1/9/2007 DOI: 10.1136/bmj.39274.647465.BE**

Objective To assess the effect of community prescribing of an antibiotic for acute respiratory infection on the prevalence of antibiotic resistant bacteria in an individual child. Study design Observational cohort study with follow-up at two and 12 weeks.

Setting General practices in Oxfordshire. Participants 119 children with acute respiratory tract infection, of whom 71 received a  $\beta$  lactam antibiotic. Main outcome measures Antibiotic resistance was assessed by the geometric mean minimum inhibitory concentration (MIC) for ampicillin and presence of the ICEHin1056 resistance element in up to four isolates of Haemophilus species recovered from throat swabs at recruitment, two weeks, and 12 weeks. Results Prescribing amoxicillin to a child in general practice more than triples the mean minimum inhibitory concentration for ampicillin (9.2  $\mu$ g/ml v 2.7  $\mu$ g/ml, P=0.005) and doubles the risk of isolation of Haemophilus isolates possessing homologues of ICEHin1056 (67% v 36%; relative risk 1.9, 95% confidence interval 1.2 to 2.9) two weeks later. Although this increase is transient (by 12 weeks ampicillin resistance had fallen close to baseline), it is in the context of recovery of the element from 35% of children with Haemophilus isolates at recruitment and from 83% (76% to 89%) at some point in the study. Conclusion The short term effect of amoxicillin prescribed in primary care is transitory in the individual child but sufficient to sustain a high level of antibiotic resistance in the population.

**Denneboom W, et al Treatment reviews of older people on polypharmacy in primary care: cluster controlled trial comparing two approaches. *British Journal of General Practice* 2007;57 (542) :723-31.**

Background: Older people are prone to problems related to use of medicines. As they tend to use many different medicines, monitoring pharmacotherapy for older people in primary care is important. AIM: To determine which procedure for treatment reviews (case conferences versus written feedback) results in more medication changes, measured at different moments in time. To determine the costs and savings related to such an intervention. Design of study: Randomised, controlled trial, randomisation at the level of the community pharmacy. Setting: Primary care; treatment reviews were performed by 28 pharmacists and 77 GPs concerning 738 older people ( $\geq 75$  years) on polypharmacy ( $>$ five medicines). Method: In one group, pharmacists and GPs performed case conferences on prescription-related problems; in the other group, pharmacists provided results of a treatment review to GPs as written feedback. Number of medication changes was counted following clinically-relevant recommendations. Costs and savings associated with the intervention at various times were calculated. Results: In the case-conference group significantly more medication changes were initiated (42 versus 22, P = 0.02). This difference was also present 6 months after treatment reviews (36 versus 19, P = 0.02). Nine months after treatment reviews, the difference was no longer significant (33 versus 19, P = 0.07). Additional costs in the case-conference group seem to be covered by the slightly greater savings in this group. Conclusion: Performing treatment reviews with case conferences leads to greater uptake of clinically-relevant recommendations. Extra costs seem to be covered by related savings. The effect of the intervention declines over time, so performing treatment reviews for older people should be integrated in the routine collaboration between GPs and pharmacists

**Kieve, M Adverse drug reactions (ADRs): a patient perspective on assessment and prevention in primary care *Quality in Primary Care* 2007 15 (4) 221-228**

A British Medical Association (BMA) report *Reporting Adverse Drug Reactions*, May 2006, estimated that 250 000 people a year are admitted to hospital suffering harmful effects of prescription drugs at a cost to the NHS of about £466 million a year. This is based on a 2004 study of hospital admissions. The BMA report draws attention to a crisis in public health that is largely being ignored and considers how medical education is failing both patients and doctors. The number of patients suffering and deaths due to adverse drug reactions (ADRs), addiction and withdrawal problems is underestimated, often unrecognised and not well reported. Ignoring the problem is costly in financial and human terms. The following paper describes the importance of the patient experience and recommends the need for systematic changes in practice and education of both the profession and the public in the recognition of ADRs. The paper includes recommendations for primary care trusts to be proactive in encouraging professional and patient Yellow Card ADR reporting, and to remind doctors of their moral duty to inform coroners of possible ADRs that may have preceded sudden death, suicide or fatal accidents. The paper concludes by emphasising the need for good practice in monitoring the side-effects of medicines, in order that patients gain the maximum benefits from their medicines

**Martens JD et al Effects of a behaviour independent financial incentive on prescribing behaviour of general practitioners. *Journal of Evaluation in Clinical Practice* . 2007;13 (3) :369-73. DOI: 10.1111/j.1365-2753.2006.00707.x**

Rationale and objectives: It is difficult to keep control over prescribing behaviour in general practice. The purpose of this study was to assess the initial effects of a behaviour independent financial incentive on the volume of drug prescribing of general practitioners (GPs). Design: 2-Year Controlled Before After study with an intervention region and a concurrent control region. Setting and participants: GPs in two regions in the Netherlands (n = 119 and n = 118). Intervention: A financial incentive for prescribing according to local guidelines on specific drugs or drug categories. The financial incentive consisted of a non-recurrent, behaviour-independent allowance. Main outcome measure: Change in the number of prescriptions for 10 targeted drugs or drug groups. RESULTS: Significant changes were seen only in three types of antibiotics and in recommended gastric medicines. In almost all cases, effects were temporary. Conclusion: Behaviour independent financial incentives can be a help in changing prescription behaviour of GPs, but effects are small-scale and temporary

**Riou F, et al Results of a 12-month quality-circle prescribing improvement programme for GPs. *British Journal of General Practice* . 2007;57 (540) :574-6.**

The impact of a quality-circle GP prescribing improvement programme, implemented in France in 2001-2002, was assessed by a controlled study. The study involved all 27 GPs of three semi-rural areas of Brittany, France. Practice data (overall prescribing cost and markers of prescribing efficiency) were collated in an intention-to-treat analysis, using the Mann-Whitney U test. Twenty-four GPs attended the meetings regularly. The

reduction in drug expenditure exceeded the cost of the programme, although variations in size effects were observed among the settings

**van Driel ML, et al . What is the role of quality circles in strategies to optimise antibiotic prescribing? A pragmatic cluster-randomised controlled trial in primary care. *Quality and Safety in Health Care* 2007; 16 (3) :197-202. DOI: 10.1136/qshc.2006.018663**

Objective: To evaluate the effect on antibiotic prescribing of an intervention in existing local quality circles promoting an evidence-based guideline for acute rhinosinusitis. Design: A pragmatic cluster-randomised controlled trial comparing standard dissemination of the guideline by mail with an additional strategy using quality circles. Setting: General practice in Flanders, Belgium. Participants: General practitioners (GPs) in 18 local quality circles were randomly allocated to two study arms. All GPs received the guideline by mail. GPs in the nine quality circles allocated to the intervention arm received an additional group intervention, which consisted of one self-led meeting using material introduced to the group moderator by a member of the research team. Main outcome measures: Adherence to the guideline was measured as differences in the proportion of antibiotic prescriptions, including the choice of antibiotic, between the two study arms after the intervention period. GPs registered their encounters with patients presenting with signs and symptoms of acute rhinosinusitis in a booklet designed for the study. Results: A total of 75 doctors (29% of GPs in the participating quality circles) registered 408 consultations. In the intervention group, 56.9% of patients received an antibiotic compared with 58.3% in the control group. First-choice antibiotics were issued in 34.5% of antibiotic prescriptions in the intervention group compared with 29.4% in the control group. After adjusting for patient and GP characteristics, the ORadj for antibiotics prescribed in the intervention arm compared with the control arm was 0.63 (95% CI 0.29 to 1.37). There was no effect on the choice of antibiotic (ORadj 1.07, 95% CI 0.34 to 3.37). Conclusion: A single intervention in quality circles of GPs integrated in the group's normal working procedure did not have a significant effect on the quality of antibiotic prescribing. More attention to the context and structure of primary care practice, and insight into the process of self-reflective learning may provide clues to optimise the effectiveness of quality circles

**van Duijn HJ, et al . Illness behaviour and antibiotic prescription in patients with respiratory tract symptoms. *British Journal of General Practice* . 2007; 57 (540) :561-8.**

Background: Although the vast majority of respiratory tract symptoms are self-limiting, many patients visit their GP for these symptoms and antibiotics are over-prescribed. Aim: To explore determinants of patients visiting GPs for recent cough, sore throat, or earache; for being prescribed antibiotics; and for patients' satisfaction with visiting the GP. Design of the study: Second Dutch National Survey of General Practice (DNSGP-2) with a health interview and an additional questionnaire. Setting: A total of 7057 adult patients of 163 GPs in the Netherlands. Method: Characteristics of patients and GPs as well as morbidity data were derived from the DNSGP-2 and a health interview. Characteristics of

the symptoms, GPs' management and patients' satisfaction were measured by an additional written questionnaire. Data were analysed by means of multivariate logistic regression. Results: About 40% of the responders (n = 1083) reported cough, sore throat, or earache in the 2 weeks preceding the interview and, of them, 250 visited their GP. Of this latter group, 97 patients were prescribed antibiotics. Apart from non-medical reasons, relevant medical factors played an important role in deciding to visit the GP. Smokers and patients with cardiac disease or diabetes mellitus were not especially inclined to see their GP. Smoking behaviour, fever, and views on respiratory tract symptoms and antibiotics of patients and GPs were associated with being prescribed antibiotics. Patients' perception of having been carefully examined was associated with their satisfaction, while receiving antibiotics was not. Conclusion: GPs should inform patients with clear elevated risk when to visit their GP in cases of cough, sore throat, or earache. There is still a need for GPs and patients to be better informed about the limited significance of single inflammation signs (for example, fever and green phlegm) as an indication for antibiotics. Careful examination of the patient contributes to patient satisfaction

## MENTAL HEALTH

**Burns T, et al Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *British Medical Journal* 2007;335 (7615) :336. DOI: 10.1136/bmj.39251.599259.55**

Objectives: To explain why clinical trials of intensive case management for people with severe mental illness show such inconsistent effects on the use of hospital care. Design: Systematic review with meta-regression techniques applied to data from randomised controlled trials. Data sources: Cochrane central register of controlled trials, CINAHL, Embase, Medline, and PsychINFO databases from inception to January 2007. Additional anonymised data on patients were obtained for multicentre trials. Review methods: Included trials examined intensive case management compared with standard care or low intensity case management for people with severe mental illness living in the community. We used a fidelity scale to rate adherence to the model of assertive community treatment. Multicentre trials were disaggregated into individual centres with fidelity data specific for each centre. A multivariate meta-regression used mean days per month in hospital as the dependent variable. Results: We identified 1335 abstracts with a total of 5961 participants. Of these, 49 were eligible and 29 provided appropriate data. Trials with high hospital use at baseline (before the trial) or in the control group were more likely to find that intensive case management reduced the use of hospital care (coefficient -0.23, 95% confidence interval -0.36 to -0.09, for hospital use at baseline; -0.44, -0.57 to -0.31, for hospital use in control groups). Case management teams organised according to the model of assertive community treatment were more likely to reduce the use of hospital care (coefficient -0.31, -0.59 to -0.03), but this finding was less robust in sensitivity analyses and was not found for staffing levels recommended for assertive community treatment. Conclusions: Intensive case management works best when participants tend to

use a lot of hospital care and less well when they do not. When hospital use is high, intensive case management can reduce it, but it is less successful when hospital use is already low. The benefits of intensive case management might be marginal in settings that have already achieved low rates of bed use, and team organisation is more important than the details of staffing. It might not be necessary to apply the full model of assertive community treatment to achieve reductions in inpatient care

**Cleland J A et al Associations of depression and anxiety with gender, age, health-related quality of life and symptoms in primary care COPD patients *Family Practice* 24 (3) 217- 223**

Background: Under-diagnosis of anxiety and depression in Chronic Obstructive Pulmonary Disease (COPD) patients may have a negative impact on patient quality of life and result in disparity between prevalence and the recognition and treatment of these symptoms. Objective: To reveal associations of depression and anxiety with demographic, health-related quality of life and clinical characteristics of COPD patients seen in UK primary care. Methods: cross-sectional population-based postal survey of COPD patients comprising the EQ-5D visual analogue scale (EQ-5D(VAS)), the COPD symptom control questionnaire, the Hospital Anxiety and Depression Scale, the Medical Research Council dyspnea index. Demographic and spirometric data were collected from general practice records. Results: A total of 170 (57%) patients consented to take part. Data are reported on 110 of these patients for whom up-to-date spirometry was available. Approximately one in five participants reported 'caseness' for depression (20.8%) and one in three reported anxiety (32.7%). Age and high levels of symptoms were independent predictors of anxiety and depression, as was the EQ-5D(VAS) of depression. Conclusions: These data suggest that in UK primary care, depressive and anxious symptoms in COPD are related to age and high levels of symptoms. Depression is also associated with lower patient-reported generic health status. The data suggest that assessment and treatment for depression and anxiety should be considered for all COPD patients, not just those with more severe clinical levels of disease. The potential of the EQ-5D(VAS) as a screening tool for anxiety and depression in primary care COPD patients also merits study

**Howe A, Ashton K, Hooper L. Effectiveness of educational interventions in primary care mental health: a qualitative systematic review. *Primary Care & Community Psychiatry* 2006; 11 (4) :167-78. DOI: 10.1185/135525707X183049**

Background: Primary care teams have large numbers of patients with psychological problems in their sole care, and many organisations will wish to design educational opportunities to improve and maintain their knowledge and skills. However, very few clinical tutors have clear guidance from the evidence-based literature to assist them. Previous studies have shown that simple methods such as guideline distribution rarely change professional behaviour or alter patient outcomes, and relevant reviews have rarely highlighted the key components which make interventions effective. This qualitative review extracted data from studies on educational interventions in primary mental health

care in order to evaluate effectiveness and give guidance. Methods: Systematic searching of named databases using specified keywords and time period, for both original articles and reviews, focusing on randomised controlled trials (RCTs). Data extraction and quality reviews were carried out as well as exploration of common factors associated with significant outcomes. Findings: Eighteen papers in total fitted the search criteria. Key features of significant outcomes were multifaceted educational interventions including practice based components in the intervention, such as practice visits, or use of practitioners' own patient cases and data. This finding fits with educational principles known to assist in adult learning. Recommendations: The impact of educational interventions which support constructive learning from personal data are likely to be more effective than courses working with theory alone or 'imaginary' patients, even when these are well designed and carried out. Using examples and data from practice appear to be crucial for showing clinicians their potential needs for improvement, and to engage them in an active cycle of learning. Educational interventions need to be rigorously designed, and all components evaluated, in order to know what makes them effective.

**Moussavi S. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet* 8/9/2007; 370:9590 :851-8. DOI: 10.1016/S0140-6736(07)61415-9**

**Background** Depression is an important public-health problem, and one of the leading causes of disease burden worldwide. Depression is often comorbid with other chronic diseases and can worsen their associated health outcomes. Few studies have explored the effect of depression, alone or as a comorbidity, on overall health status. **Methods** The WHO World Health Survey (WHS) studied adults aged 18 years and older to obtain data for health, health-related outcomes, and their determinants. Prevalence of depression in respondents based on ICD-10 criteria was estimated. Prevalence values for four chronic physical diseases—angina, arthritis, asthma, and diabetes—were also estimated using algorithms derived via a Diagnostic Item Probability Study. Mean health scores were constructed using factor analysis and compared across different disease states and demographic variables. The relation of these disease states to mean health scores was determined through regression modelling. **Findings** Observations were available for 245 404 participants from 60 countries in all regions of the world. Overall, 1-year prevalence for ICD-10 depressive episode alone was 3.2% (95% CI 3.0–3.5); for angina 4.5% (4.3–4.8); for arthritis 4.1% (3.8–4.3); for asthma 3.3% (2.9–3.6); and for diabetes 2.0% (1.8–2.2). An average of between 9.3% and 23.0% of participants with one or more chronic physical disease had comorbid depression. This result was significantly higher than the likelihood of having depression in the absence of a chronic physical disease ( $p < 0.0001$ ). After adjustment for socioeconomic factors and health conditions, depression had the largest effect on worsening mean health scores compared with the other chronic conditions. Consistently across countries and different demographic characteristics, respondents with depression comorbid with one or more chronic diseases had the worst health scores of all the disease states. **Interpretation** Depression produces the greatest decrement in health compared with the chronic diseases angina, arthritis, asthma, and

diabetes. The comorbid state of depression incrementally worsens health compared with depression alone, with any of the chronic diseases alone, and with any combination of chronic diseases without depression. These results indicate the urgency of addressing depression as a public-health priority to reduce disease burden and disability, and to improve the overall health of populations.

**Oud MJT, et al. How do General Practitioners experience providing care for their psychotic patients? *BMC Family Practice* 2007;8: 37 DOI: doi:10.1186/1471-2296-8-37**

**Background** In primary care, GPs usually provide care for patients with chronic diseases according to professional guidelines. However, such guidelines are not available in the Netherlands for patients with recurring psychoses. It seems that the specific difficulties that GPs experience in providing care for these patients hinder the development and implementation of such guidelines. This study aims to explore the chances and problems GPs meet when providing care for patients susceptible for recurring psychoses, including schizophrenia and related disorders, bipolar disorder, and psychotic depression. **Methods** A qualitative study of focus group discussions with practising GPs in both town and rural areas. Transcripts from three focus groups with 19 GPs were analysed with the computer program Kwalitan. Theoretical saturation was achieved after these three groups. **Results** Analysis showed that eight categories of factors influenced the GPs care for psychotic patients: patient presentation (acute vs. chronic phase), emotional impact, expertise, professional attitude, patient related factors, patients family, practice organization, and collaboration with psychiatric specialists. **Conclusion** Current primary care for psychotic patients depends very much on personal characteristics of the GP and the quality of local collaboration with the Mental Health Service. A quantitative study among GPs using a questionnaire based on the eight categories mentioned above would determine the extent of the problems and limitations experienced with this type of care. From the results of this quantitative study, new realistic guidelines could be developed to improve the quality of care for psychotic patients.

**Paile-Hyvarinen M, Wahlbeck K, Eriksson JC. Quality of life and metabolic status in mildly depressed patients with type 2 diabetes treated with paroxetine: A double-blind randomised placebo controlled 6-month trial. *BMC Family Practice* 2007;8:34 DOI: doi:10.1186/1471-2296-8-34**

**Background** Depression is prevalent in people with type 2 diabetes and affects both glycaemic control and overall quality of life. The aim of this investigator-initiated trial was to evaluate the effect of the antidepressant paroxetine on quality of life, metabolic control, and mental well-being in mildly depressed diabetics aged 50-70 years. **Methods** We randomised 49 mildly depressed primary care outpatients with non-optimally controlled diabetes to a 6-month double-blind treatment with either paroxetine 20 mg per day or matching placebo. Primary efficacy measurements were quality of life and glycaemic control. The primary global outcome of the study was defined as a 10 points

improvement in the SF-36 quality of life score. The primary metabolic outcome of the study was defined as a 0.8%-units decrease in glycosylated haemoglobin A1c (GHbA1c). Psychiatric symptoms were assessed with the Hospital Anxiety and Depression Scale. Results Six patients withdrew their consent before starting medication and six dropped out later in the study. We performed analysis of covariance with the baseline value as a covariate. Quality of life and glycaemic control as well as symptoms of depression and anxiety improved in both groups over the 6-month study period. After three months of treatment we found a statistically significant difference between the two treatment groups in GHbA1c (mean difference= 0.59%-units, p=0.018) and in SF-36 score (mean difference=11.0 points, p=0.039). However, at the end of the study, no statistically significant differences between the treatment groups were observed. No severe adverse events occurred. Conclusion This pragmatic study of primary care patients did not confirm earlier preliminary findings indicating a beneficial effect of paroxetine on glycaemic control. The study indicates that in pragmatic circumstances any possible benefit from administration of paroxetine in diabetic patients with sub-threshold depression is likely to be modest and of short duration. Routine antidepressant prescription for patients with diabetes and sub-threshold depressive symptoms is not indicated. Trial registration: <http://www.controlled-trials.com/ISRCTN55819922>

**Reeve J, Lloyd-Williams M, Dowrick C. Depression in terminal illness: the need for primary care-specific research. *Family Practice* 2007;24 (3) :263-8.**

Abstract: Background: Palliative care research highlights depression as a common, treatable condition in patients with terminal cancer. Guidance from the European Association for Palliative Care calls for proactive screening and treatment of the disease. However, prevalence of depression among primary care patients with advanced cancer is unknown and it remains uncertain whether existing guidance is appropriate for use by GPs. Objective: To estimate the prevalence of depression in a primary care population with terminal cancer. Methods: A two-stage community prevalence survey conducted in primary care practices in Merseyside, UK. Adult patients with advanced metastatic cancer were invited to join the study. In phase 1, a depression screening tool (the Edinburgh Depression Scale [EDS]) was used to categorize patients as being high or low risk of depression. In phase 2, samples from each group underwent a diagnostic assessment using the revised Clinical Interview Schedule. Weighted prevalence estimates were calculated. Results: in a final sample of 70 (response rate 47.9%), the prevalence of depression was 4.1% (95% confidence interval 0-8.8%). The sensitivity and specificity of the EDS were poorer than predicted. Conclusion: The prevalence of depression in our sample was lower than expected given findings from previous studies. Screening tools also performed differently in this population. The limitations in our study are discussed; however, our findings raise questions about whether depression guidance from palliative care studies can be directly applied to a primary care setting. We propose the need for development of a primary palliative care evidence base to underpin appropriate clinical

**Stip E, et al. General population perceptions and attitudes towards schizophrenia and bipolar disorder. *Primary Care & Community Psychiatry* 2006; 11 (4) :157-66. DOI: 10.1185/135525707X183003**

Objectives: Participatory action research (PAR) involving people with mental illness or family members is an advantage when social integration and the gap between mentally ill patients and the society are to be assessed. This study investigated the perception and attitude of the general population of Quebec (Canada) regarding two major mental illnesses: bipolar disorder and schizophrenia. Methods: One thousand and one interviews were conducted with a representative sample of the adult population. PAR was implemented in developing the questionnaires and items listing used in this study. This approach was seen as a first step in a new collaboration between two milieus (academia and consumer), to support hypothesis usually well formulated by researchers. Results: The response rate was 60.7%. The perception of the etiology, behavior, attitude, stigma and medication with regards to bipolar disorder and schizophrenia were collected. In general, no differences were observed with regards to mother tongue, number of individuals in the household nor geographic region. Higher education and younger age were associated with more acceptance and better understanding of the etiology and treatment of mental illness. Compared to bipolar disorder, schizophrenia was perceived as a more severe mental illness, less tolerated and more stigmatized. Conclusion: There was a strong association between the level of education and knowledge of mental illness. Thus, further efforts aimed at increasing knowledge and acceptance towards mental illness is required. Furthermore, new survey approaches that address the concerns of both academia and consumers should be created for future studies.

**Voros V, et al. Screening for suicidal behaviour and mental disorders with Prime-MD Questionnaire in general practice. *Primary Care & Community Psychiatry* 2006; 11 (4):193-6. DOI: 10.1185/135525707X183067**

- Background: The major risk factors for completed suicide are previous suicide attempts and mental disorders. Lifetime prevalence of suicide attempts is 3-4%; and primary care is a major basis for suicide prevention. Aim: To assess the value of a screening method developed to determine the prevalence of suicidal behaviour, and to describe the characteristics of suicide attempters in primary care, including screening for major mental disorders. Methods: A Hungarian urban general practitioner's district with 1248 inhabitants was screened for suicidal behaviour and for major mental disorders. The Prime-MD questionnaire (Primary Care Evaluation of Mental Disorders) was used to recognize the most common psychiatric disorders; suicidal behaviour was assessed by six structured questions of MINI-Plus diagnostic interview. Results: Prevalence of patients with suicide attempts in primary care was 2.9%; 9% of the patients had either suicidal thoughts or gestures the month before. Self-destructive thoughts or behaviour often coexisted with depressive disorders, 60% of suicidal patients and 11.5% of the screened population had depressive episode. According to multivariate logistic regression, suicidal

patients were more likely to take antidepressants, they also had a tendency to have more previous psychiatric treatments and suicide attempts; they visited their General Practitioners less frequently and were more likely to have current depressive episodes. Conclusion: The Prime-MD questionnaire, complemented with questions on suicidal behaviour, is an effective, easy-to-use method for general practitioners to assess suicide risk and to recognize the most common mental disorders. This method can be of great help and is proposed for use by general practitioners in every-day practice.

## **NEED AND DEMAND FOR CARE**

**Barnett, H** **Complementary and alternative medicine and patient choice in primary care Quality in Primary Care 2007 15 (4) 207-212**

Complementary and alternative medicine (CAM) is widely used in addition to or instead of conventional medicines for positive or negative reasons. Negative reasons are a poor outcome from conventional treatment; unwanted effects from drugs; a negative experience of the general practitioner relationship; and health views not in line with the conventional medical model. Positive reasons are a good outcome from CAM treatment; being an active participant in health care; a positive experience of the CAM practitioner relationship; and health views in line with the CAM model. This paper discusses how complementary and alternative therapies may be used to address important gaps in NHS provision not amenable to conventional therapy.

**Glynn LG, Macfarlane A, Murphy AW. The complexity of patients' satisfaction with out-of-hours care: A qualitative study. *European Journal of General Practice* 2007; 13 (2) :83-8. DOI: 10.1080/13814780701410199**

Background: The national health service in the Republic of Ireland is one of a number of European health services currently undergoing significant reform. Out-of-hours primary care has been at the forefront of this process of change, and although patients appear satisfied, the complexity of their response to changes in out-of-hours care has not been fully explored. Objective: To conduct an analysis of qualitative data collected during a recent study of patients' satisfaction with out-of-hours care in order to explore the full range of patients' views and experiences. Methods: All patients contacting a family-doctor out-of-hours cooperative over a designated 24-day period were forwarded a postal questionnaire. The questionnaire contained a section giving the patient the opportunity to add qualitative comments concerning their experience. The data were analysed according to the principles framework analysis using Nvivo software. Results: Analysis of the data resulted in the development of the following thematic categories: service availability,

service accessibility, efficiency, continuity of care and quality of care. There was a range of views, both positive and negative, apparent around these themes, with evidence of patients engaging in careful decisions and "trade-offs" in respect of their options for out-of-hours care. Conclusion: Patients hold a range of views that suggests the complexity around patient satisfaction with out-of-hours care. A qualitative methodological approach can compliment current approaches to the evaluation of patient satisfaction, facilitating the exploration of the full range of patients' views and experiences

**Turner D: Do patients value continuity of care in general practice: an investigation using stated preference discrete choice experiments** *Journal of Health Services Research and Policy* 2007 12 (3) 132-137 DOI: 10.1258/135581907781543021

Objectives: To estimate the relative importance to patients of continuity of care compared with other aspects of a primary care consultation. Methods: We carried out a discrete choice experiment in Leicestershire and London on a stratified random sample of 646 community dwelling adults taken from general practitioner (GP) registers, plus 20 interviews with Punjabi, Urdu and Gujarati speakers. The attributes examined were: the type of professional consulted, relational continuity, informational continuity and access. Results: Individuals' values changed according to their reason for making a primary care consultation. If consulting for minor familiar symptoms, individuals would be prepared to trade off one extra day's wait to see a GP rather than a nurse, 0.9 days for relational continuity, and 1.6 days for informational continuity. If consulting for a new condition they were uncertain about, they would be prepared to trade off an additional wait of 3.5 days to see a GP rather than a nurse, 2.4 days for relational continuity and 3.9 days for informational continuity. For a routine check-up, an individual would be prepared to trade off an additional wait of 3.5 days to see a GP rather than a nurse, 4.2 days for relational continuity and 7.8 days for informational continuity. Conclusions: Respondents stated their preference to wait longer to see a familiar medical practitioner who was well informed about their case when they had a problem causing uncertainty or needed a routine check-up. They preferred quick access for likely minor 'low impact' symptoms. Appointment systems in general practice should be sufficiently flexible to meet these different preferences

## ORGANIZATIONS

**Paton C. He who rides a tiger can never dismount: six myths about NHS reform in England. *International Journal of Health Planning and Management* 2007;22 (2) :97-111. DOI: 10.1002/hpm.887**

Abstract: With the demise of Prime Minister Blair, the demoralization of his 'New Labour' party and the resurgence of right-of-centre think tanks in England (such as Reform), the idea that the public sector in general-and the NHS in particular-requires more 'radical reform' has gained currency. To some, this means more market, aping the private sector even more than in the Thatcher years; to others, it means more, overt privatization. I intend here to consider the case of the NHS, where that claim is used by the Right to further its agenda and often accepted by the Left by default.

**Wallace LM, et al Organizational interventions to promote risk management in primary care: the experience in Warwickshire, England. *Health Services Management Research* 2007; 20 (2) :84-93. DOI: 0.1258/095148407780744651**

Primary care organizations are under-represented in research on quality improvement and risk management (RM), yet the potential for improving patient safety is possibly greater given the extent that clinical judgement is required to achieve a service tailored to the individual's personal health and lifestyle. This paper examines how a health authority in England promoted interventions to improve RM in General Practice that included the practices' own initiatives, significant event audit (SEA) and the Medical Defence Union's workshops which included SEA. All 75 practices were approached before the programmes and when they were finished, eight months later. The practice manager from each practice completed an audit of RM activities, from which a RM competence score was derived. Up to six staff per practice completed the Learning organization Culture Questionnaire (LCQ) at both times. There was evidence of improved competence in RM over the period of the study, particularly through a widening breadth of staff involved and in formal recording systems. There was little evidence that these improvements were mediated by organizational culture. It is argued that future interventions should more closely target specific competences (e.g. recording systems for adverse events, root cause analysis to understand error generation) and enable staff to see tangible personal and organizational benefits for the extra effort involved

**Warwick P. Back to the future in NHS reform *Journal of Health Organization and Management* 2007; 21: (2) 194-204.**

Purpose - In the mid 1990s the NHS "did" competition, in the mid 2000s the NHS is

"doing" choice. This paper aims to cut through the rhetoric, highlight the differences and parallels between then and now and identify if these differences will have a different or the same impact on local services. Design/methodology/approach - Following a review of literature from the 1990s, a qualitative research study is used to examine the impact of competition and markets in the 1990s. The discussion examines the implications of this study for current system reform. Findings - Patient choice recreates many of the features of the internal market, but despite concerns at the time, the internal market did not have a significant impact on services. It is likely that patient choice will similarly have a limited impact. Research limitations/implications - The research is a case study confined to Day Surgery in one part of the North of England. Originality/value - The paper reminds academics and practitioners what happened last time the NHS attempted to introduce a market-based system.

## **PATIENT AND PUBLIC INVOLVEMENT**

**Blennerhassett M** Challenges for primary care in the age of the autonomous patient *Quality in Primary Care* 2007 15 (4) 201-206

Patient expectations of and concerns about health care have changed over recent years and now present new challenges to the primary care clinician. Involving patients and carers more widely in general practice services (and also medical education), and accepting their views is essential to achieving patient-centred services and is likely to enhance doctors' standing in patients' eyes.

**Conway S, Crawshaw P, Bunton R** 'There is a Mantra of: "Community Involvement is Good", and We All Tick the Boxes and Say We Have Done the Consultation': Health Action Zones and the Normative Principles of Government *Social Theory and Health* 5 (3) 208-227 DOI: 10.1057/palgrave.sth.8700094

This paper explores the interpretation of discursive governmental 'regimes of truth' related to accounts of community involvement by personnel involved in a Health Action Zone. It is based upon in-depth interviews and follows the conventions of thematic analysis. The analysis identifies a range of narratives among the respondents that often privilege experience over aspects of governmental discourse that are seen as oversimplified and technical in nature. This points to the challenges involved in transforming governmental discourse related to community into meaningful policy and practice aimed at profoundly socially disadvantaged 'communities.' The paper contributes to understanding about the processes that generate and inhibit the success of community involvement for welfare policy. In overall terms, it may serve as a sociologically 'sensitizing' and theoretical contribution to debates about community and public policy.

**Daykin N, et al. Evaluating the impact of patient and public involvement initiatives on UK health services: a systematic review . *Evidence & Policy* 2007; 3 (1) : 47- 65. DOI: 10.1332/174426407779702201**

This article reports on a systematic review of the patient and public involvement (PPI) literature in the UK that was undertaken in 2005 to support an evaluation of the Patient Advice and Liaison Services (PALS) in England. The general PPI literature has been extensively reviewed; here we focus on the relatively small empirically based evaluation literature. The research adopts the framework of realistic evaluation, which identifies contexts, mechanisms and outcomes that lead to favourable and unfavourable outcomes. The question guiding the review is therefore: 'What context and mechanism factors can be identified from empirical research that will lead to successful PPI outcomes?'.

**Horrocks S, Coast J Patient choice: an exploration of primary care dermatology patients' values and expectations of care *Quality in Primary Care* 2007 15 (4) 185-194**

Background Skin complaints are an important cause of ill-health accounting for a large number of general practitioner (GP) consultations and referrals to secondary care. Organisational developments in the UK have led to GPs with a special interest (GPSI) in dermatology offering outpatient services in a primary care setting; however, an in-depth exploration of the values dermatology patients attach to aspects of care or the acceptability of variations in secondary care service delivery has not been reported. Aim To identify and explore the aspects of care dermatology patients deemed important in making choices about service use. Design A qualitative study carried out alongside a randomised controlled trial to compare effectiveness of a GPSI dermatology service with standard consultant-led dermatology outpatient care. Setting United Kingdom. Method Semi-structured interviews with primary care patients referred for routine dermatology outpatient appointments. Results Participants referred for routine outpatients appointments had skin conditions which ranged in severity and impact on their quality of life. Those with minor skin complaints expected their GP to be able to provide more treatments at their local surgery. Some participants who had experienced unsuccessful treatment by their GP reported difficulties in obtaining a specialist referral. Variation in perception and relative importance of the constituents of specialist care was highlighted. Primary care-based specialist services are not always accessible to those living outside the immediate vicinity. Conclusion GPs should be aware of the impaired quality of life experienced by some patients with chronic skin complaints. GPSI services were acceptable to the majority. However, there is likely to be a group of patients with longstanding, though clinically non-urgent, conditions for whom the service will not be acceptable.

**Legge D G, et al. Micro macro integration: Reframing primary healthcare practice and community development in health. *Critical Public Health* 2007; 17 (2) :171-82. DOI: doi: 10.1080/09581590601045196**

The idea of micro macro integration (MMI) provides a useful framework for thinking about primary healthcare (PHC) and community development in health (CD). PHC and CD are important strategies for addressing the structural determinants of health. They are each based on a powerful logic and have a significant body of support. However, while exemplary, even inspiring, instances of practice are common, attempts to replicate models of good practice (or 'scale up') often flounder. As frameworks for analysing this paradox, both PHC and CD have limitations, partly because they are overburdened with different and conflicting meanings. This paper explores an alternative framework based on a common aspiration of both PHC and CD: to effect change at both the micro level (meeting the immediate health needs of individuals, families and communities) and also at the macro level (of political, economic and social structures). The MMI framework assumes that health issues can be analysed at different levels of scale and of term (from the micro to the macro); that objectives and strategies can be conceived at these different levels; and that a coherent programme of activities can be conceived and implemented which addresses both the immediate and local problems and the larger scale and longer term phenomena that reproduce those patterns of need. The idea of MMI is less ambitious than either PHC or CD but (partly because of this) has value as a framework for analysing barriers to good practice.

**Schouten BC, et al. Cultural diversity in patient participation: The influence of patients' characteristics and doctors' communicative behaviour. *Patient Education and Counseling* 2007; 67 (1-2) :214-23. DOI: 10.1016/j.pec.2007.03.018**

**Objective** The primary goal of this study was to examine the extent to which patient participation during medical visits is influenced by patients' ethnic background, patients' culture-related characteristics (e.g. acculturation, locus of control, cultural views) and features of doctors' communicative behaviour. Furthermore, the mutual influence between patients' participatory behaviour and doctors' communicative behaviour was investigated. An additional goal was to identify the independent contribution of these variables to the degree of patient satisfaction and mutual understanding between GP and patient. **Methods** Communicative behaviour of patients ( $n = 103$ ) and GPs ( $n = 29$ ) was analysed with Roter's Interaction Analysis System, frequency of patient questions and patients' assertive utterances (e.g. making requests, suggesting alternative treatment options). Additional data were gathered using GP and patient questionnaires after the consultations. **Results** Results show that non-Western ethnic minority patients display less participatory behaviour during medical consultations than Dutch patients. GPs' affective verbal behaviour had most effect on degree of patient participation and patient satisfaction. Regression analyses indicate a significant mutual influence between patients' verbal behaviour and GPs' verbal behaviour. **Conclusion** Overall, results of this study show some important differences between Dutch and non-Western ethnic minority patients in degree of patient participation. Furthermore, our results indicate that patient participation encompasses several aspects that are not necessarily interrelated. **Practice implications** The necessity for continued education of GPs' communicative skills, particularly when dealing with non-Western ethnic minority patients, is reflected in the strong influence of GP's affective verbal behaviour on both patient participation and their satisfaction with the medical encounter.

**Tokuda Y, et al. Health locus of control and use of conventional and alternative care: a cohort study. *British Journal of General Practice* . 2007; 57 (541) : 643-9.**

Background: Health locus of control influences health-related behaviour, but its association with healthcare use is unclear. Aim: To investigate the association between individuals' health locus of control and the use of conventional and alternative health care. Design of study: Prospective cohort study. Setting: A nationally representative random sample of community-dwelling adult households in Japan. Method: Health locus of control, symptom-related visits to physicians, and the use of dietary and physical complementary and alternative medicine (CAM) was measured. Dietary CAM included supplements, such as herbs and vitamins. Physical CAM included manipulations, such as acupuncture and acupressure. Results: Of the 2453 adult participants studied, 2103 (86%; 95% CI [confidence interval] = 84 to 88%) developed at least one symptom during the 31-day study period. Of these symptomatic adults, 639 visited physicians (30%; 95% CI = 28 to 32%), 480 used dietary CAM (23%; 95% CI = 21 to 25%), and 156 (7%; 95% CI = 6 to 9%) used physical CAM. The likelihood of visiting a physician was not related significantly to individuals' health locus of control. Increased use of dietary CAM was weakly associated with control by spiritual powers ( $P = 0.028$ ), internal control ( $P = 0.013$ ), and less control by professionals ( $P = 0.020$ ). Increased use of physical CAM was significantly associated with control by spiritual powers ( $P = 0.009$ ) indicating a belief that supernatural forces control individuals' health status. Conclusion: The likelihood of visiting a physician is not affected by individuals' health locus of control. Control by spiritual powers is involved with increased CAM use. Internal control is weakly associated with greater use of dietary CAM; professional control is weakly associated with less use of dietary CAM

## **PRIMARY/SECONDARY CARE INTERFACE**

**Abholz HH. Conflicts between personal and public health care: can one GP serve two masters? *British Journal of General Practice*. 2007;57:693-4.**

General practice has always been placed between personal care and public health duty. But the latter has not been an integral part of general practice for very long and is still poorly integrated in countries like Germany, Austria, and France. But even in those countries, working as a GP often includes a public health approach, and GPs' role - in the language of social science - is defined by public health, as well as by the requirements of personal care.

**Calnan M, et al** A qualitative study exploring variations in GPs' out-of-hours referrals to hospital. *British Journal of General Practice*. 2007; 57 (542) :706-13.

Background: There is evidence of significant variations in hospital referral rates for GPs working in out-of-hours care. Aims: To explain why there are marked variations in hospital referral rates for GPs working in out-of-hours care. Design of study: In depth, face-to-face interviews with a purposive sample of GPs with different out-of-hours referral rates. Setting: Bristol, UK. Method: GPs were selected according to their rate of out-of-hours hospital referral. They were classified as high, medium, or low referrers. Five interviews were carried out with GPs from each of the three categories. Results: High referring GPs are typically cautious and believe it is better to admit if in doubt. They express anxiety about the consequences of a decision not to admit, both for the patient and for themselves. They hold negative attitudes towards alternatives to hospital admission. Low referrers were more confident about their decisions and less often worried afterwards. Low referrers were positive about alternatives to hospital admission and described themselves as able to resist pressures from family or carers to have someone admitted. Low referrers also see hospitals as places to be avoided and viewed their goal as preventing an admission. Conclusion: Educational programmes need to be developed to improve GPs' judgements of their competences and to build appropriate levels of confidence

**Crilly T, Plant M.** Reforming emergency care: Primary Care Trust power in action research. *Health Services Management Research* 2007; 20 (1) :37-47. DOI; 10.1258/095148407779614954

Objectives: A Primary Care Trust (PCT) used its position as lead commissioner in a health economy to search for efficiency gains and to improve the patient journey through accident and emergency (A&E) services in a hard-pressed acute hospital. The project generated an action research approach. As a by-product, we developed a model of the hospital system based on a case study that can be replicated and used to set utilization targets at the micro-level of the hospital organization. This addresses a gap in the literature on hospital utilization that currently focuses on macro-population levels of analysis or simulation models that demand complex data. Primary and secondary care services, in contrast, require a pragmatic model of utilization supported by a few key, readily available data items. Methods: Mixed quantitative and qualitative methods were adopted in an approach of collaborative enquiry among stakeholders of the health economy. We used the flexible planning tenet of action research that evolved into the subjective meaning tenet by which, to achieve authoritative findings, it was necessary to broaden the line of enquiry to address participants' perceptions. Results: We have described the current patient flow and a redesigned pathway through A&E services together with targets and action required to reduce admissions, delayed discharges and diagnostic waits in the emergency hospital system. Primary care had a key role in changing the culture, communication and treatment within A&E services. Conclusion: (i) This study was rapid and sustained a high level of energy and purpose among

stakeholders. Action research is an appropriate method to apply to transformational change in the modernization of health-care systems; (ii) Modelling of system dynamics is a critical dimension to the success of whole system change; (iii) Primary care commissioning power is an under-used, but influential, lever for change. At a point when the PCT commissioning structure is under threat, this project exemplifies primary care's ability to engineer change in acute hospital services

**McCoy D, et al Carrot and sticks? The Community Care Act (2003) and the effect of financial incentives on delays in discharge from hospitals in England. *Journal of Public Health (Oxf)* Sep;29(3) 2007 :281-7 . Epub 24 July 2007 DOI: 10.1093/pubmed/fdm026**

Background: The belief that many delays in discharge from hospital were caused by social service departments (SSDs) led to the Community Care Act 2003 giving NHS hospitals in England the power to charge SSDs. Methods: We surveyed 150 SSDs in England about the implementation of the Act and used routine data to analyse trends in the number of delayed discharge patients; the number and cause of delayed discharge bed days by sector; and the proportion of inpatient bed days that consisted of delayed discharges. Findings Most hospitals opted not to charge SSDs for delays. Almost two thirds of SSDs (62%) made no payment of any kind to an acute hospital in 2004/05 and 2005/06, preferring to work collaboratively. The fall in number of 'delayed discharge patients' is a long term trend which precedes the implementation of the 2003 Act. Delayed discharge bed days accounted for 1.58% of all inpatient bed days in 2004/05. Contrary to popular opinion, the NHS accounted for two thirds (67%) of bed day delays, lack of suitable alternative NHS provision and services is a key factor. Patients are being discharged in greater numbers and earlier in their post-acute recovery phase. There are however questions about the quality and safety of early discharge. For example, emergency hospital readmissions rates have risen from 5.4% in 2002/03 to 6.7% in 2005/06, and patient dissatisfaction is significant. Conclusion: Although delays in discharge from acute hospital beds have fallen, the quality of discharge and the capacity of Primary Care Trusts (PCTs) and SSDs to ensure appropriate and adequate post-discharge care is not as it should be. Contrary to popular perception, social services delays are of less significance than delays attributable to the NHS. There is no evidence to support government policy of charging SSDs for delay. Other factors, including NHS provision, are important, and a comprehensive overview of health and social care is vital

**Baumann M, et al. Organisation and features of hospital, intermediate care and social services in English sites with low rates of delayed discharge. *Health and Social Care in the Community* 2007;15 (4) : 295-305. DOI: 10.1111/j.1365-2524.2007.00697.x**

In recent years, there has been significant concern, and policy activity, in relation to the problem of delayed discharges from hospital. Key elements of policy to tackle delays

include new investment, the establishment of the Health and Social Care Change Agent Team, and the implementation of the Community Care (Delayed Discharge) Act 2003. Whilst the problem of delays has been widespread, some authorities have managed to tackle delays successfully. The aim of the qualitative study reported here was to investigate discharge practice and the organisation of services at sites with consistently low rates of delay, in order to identify factors supporting such good performance. Six 'high performing' English sites (each including a hospital trust, a local authority, and a primary care trust) were identified using a statistical model, and 42 interviews were undertaken with health and social services staff involved in discharge arrangements. Additionally, the authors set out to investigate the experiences of patients in the sites to examine whether there was a cost to patient care and outcomes of discharge arrangements in these sites, but unfortunately, it was not possible to secure sufficient patient participation. Whilst acknowledging the lack of patient experience and outcome data, a range of service elements was identified at the sites that contribute to the avoidance of delays, either through supporting efficiency within individual agencies or enabling more efficient joint working. Sites still struggling with delays should benefit from knowledge of this range. The government's reimbursement scheme appears to have been largely helpful in the study sites, prompting efficiency-driven changes to the organisation of services and discharge systems, but further focused research is required to provide clear evidence of its impact nationally, and in particular, how it impacts on staff, and patients and their families

## QUALITY OF CARE

**Ashworth M, et al . The relationship between social deprivation and the quality of primary care: a national survey using indicators from the UK Quality and Outcomes Framework. *British Journal of General Practice* 2007;57 (539) :441-8.**

Background: The existence of health inequalities between least and most socially deprived areas is now well established. Aim: To use Quality and Outcomes Framework (QOF) indicators to explore the characteristics of primary care in deprived communities. Design of study: Two-year study. Setting: Primary care in England. Method: QOF data were obtained for each practice in England in 2004-2005 and 2005-2006 and linked with census derived social deprivation data (Index of Multiple Deprivation scores 2004), national urbanicity scores and a database of practice characteristics. Data were available for 8480 practices in 2004-2005 and 8264 practices in 2005-2006. Comparisons were made between practices in the least and most deprived quintiles. Results: The difference in mean total QOF score between practices in least and most deprived quintiles was 64.5 points in 2004-2005 (mean score, all practices, 959.9) and 30.4 in 2005-2006 (mean, 1012.6). In 2005-2006, the QOF indicators displaying the largest differences between least and most deprived quintiles were: recall of patients not attending appointments for injectable neuroleptics (79 versus 58%, respectively), practices opening  $\geq 45$

hours/week (90 versus 74%), practices conducting  $\geq 12$  significant event audits in previous 3 years (93 versus 81%), proportion of epileptics who were seizure free  $\geq 12$  months (77 versus 65%) and proportion of patients taking lithium with serum lithium within therapeutic range (90 versus 78%). Geographical differences were less in group and training practices. Conclusions: Overall differences between primary care quality indicators in deprived and prosperous communities were small. However, shortfalls in specific indicators, both clinical and non-clinical, suggest that focused interventions could be applied to improve the quality of primary care in deprived areas

**Campbell S et al Quality of primary care in England with the introduction of pay for performance. *New England Journal of Medicine* 2007;357 (2) :181-90. DOI:10.1056/NEJMSr065990**

In 2004, the United Kingdom committed £1.8 billion (\$3.2 billion) to a new pay-for-performance contract for family practitioners.<sup>1</sup> During the first year, the levels of achievement exceeded those anticipated by the government, with an average of 83.4% of the available incentive payments claimed.<sup>2</sup> However, the quality of care in English family practices had already begun to improve in response to a wide range of initiatives,<sup>3,4,5,6</sup> including national standards for the treatment of major chronic diseases and a national system of inspection (Table 1).

**Giesen P, et al Safety of telephone triage in general practitioner cooperatives: do triage nurses correctly estimate urgency? *Quality and Safety in Health Care* 2007; 16 (3): 181-4 .DOI: 10.1136/qshc.2006.018846**

Background: In recent years, there has been a growth in the use of triage nurses to decrease general practitioner (GP) workloads and increase the efficiency of telephone triage. The actual safety of decisions made by triage nurses has not yet been assessed. Objectives: To investigate whether triage nurses accurately estimate the urgency level of health complaints when using the national telephone guidelines, and to examine the relationship between the performance of triage nurses and their education and training. Method: A cross-sectional, multicentre, observational study employing five mystery (simulated) patients who telephoned triage nurses in four GP cooperatives. The mystery patients played standardised roles. Each role had one of four urgency levels as determined by experts. The triage nurses called were asked to estimate the level of urgency after the contact. This level of urgency was compared with a gold standard. Results: Triage nurses estimated the level of urgency of 69% of the 352 contacts correctly and underestimated the level of urgency of 19% of the contacts. The sensitivity and specificity of the urgency estimates provided by the triage nurses were found to be 0.76 and 0.95, respectively. The positive and negative predictive values of the urgency estimates were 0.83 and 0.93, respectively. A significant correlation was found between correct estimation of urgency and specific training on the use of the guidelines. The educational background (primary or secondary care) of the nurses had no significant relationship with the rate of underestimation. Conclusion: Telephone triage by triage nurses is efficient but possibly not safe, with potentially severe consequences for the

patient. An educational programme for triage nurses is recommended. Also, a direct second safety check of all cases by a specially trained GP telephone doctor is advisable

**Gray J, Bradshaw C. Assessing general practitioners who may be underperforming: local assessment methods in two English health districts. *Quality in Primary Care* 2007; 15 (3) :157-64.**

Introduction Primary care trusts (PCTs) in England are required to set in place local arrangements to identify and deal with concerns about general practitioners' (GPs') performance. Assessing GP performance at a local level can be challenging and there is little published information available to describe the methods PCTs use. This paper describes the local assessment methods developed by two PCTs. Methods Gateshead and South Tyneside PCTs have jointly developed methods to locally assess whether GPs are underperforming. The methods involve lay, clinical and management representatives and employ a variety of tools including case-based assessment and a questionnaire to colleagues. Most of these tools measure performance against the standards set out in *Good Medical Practice* or collate data derived from nationally validated surveys. The methods have been developed to promote transparency, objectivity and consistency while making the most of scarce local expertise. Results In our experience, case-based assessment and questionnaires to colleagues provide the most helpful information. Our local assessments enable practitioners to continue their work and do not incur travel or accommodation costs for the assessed or the assessors. GPs and their defence organisations find the methods acceptable. Conclusions It would be helpful for other PCTs to publicise their assessment methods so that best practice can be developed and standardised, thus ensuring that all patients and GPs receive the same levels of protection and support at a local level.

**Grol R, Wensing M. Measuring performance quality in general practice: is international harmonization desirable? *British Journal of General Practice*. 2007; 57 (542) :691-2.**

The call for transparency about quality of care provided to patients has become stronger in recent years in most developed countries. Society demands that care providers, GPs included, account for their performance, and is increasingly prepared to pay for better care. The development in accountability faces critical debate, such as questions about its impact on improving practice, and claims that it is a threat to professionalism, that it promotes strategic behaviour and even fraud, and increases bureaucracy and costs of health care

**Hankins M et al . Measuring patient satisfaction for the Quality and Outcomes Framework. *British Journal of General Practice* 2007;57 (542) :737-40.**

The general medical services (GMS) contract Quality and Outcomes Framework (QOF) awards up to 70 points for measuring patient satisfaction with either the Improving Practices Questionnaire (IPQ) or the General Practice Assessment Questionnaire (GPAQ). The usefulness of data collected depends crucially on the validity and reliability

of the measurement instrument. The literature was reviewed to assess the validity and reliability of these questionnaires. The literature was searched for peer-review publications that assessed the reliability and validity of the IPQ and GPAQ, using online literature databases and hand-searching of references up to June 2006. One paper claimed to assess the validity and reliability of the IPQ. No paper reported the reliability and validity of the GPAQ, but three papers assessed an earlier version (the GPAS). No published evidence could be found that the IPQ, GPAQ, or GPAS have been validated against external criteria. The GPAS was found to have acceptable reliability and test-retest reliability. Neither of the instruments mandated by the GMS contract has been formally assessed for reliability: their reproducibility remains unknown. The validation of the two questionnaires approved by the QOF to assess patient satisfaction with general practice appears to be suboptimal. It is recommended that future patient experience surveys are piloted for validity and reliability before being implemented widely

**Higashi T, et al. Relationship between number of conditions and quality of care. *New England Journal of Medicine* 2007 ;356 (24) :2496-504.**

**Background** There is emerging concern that the methods used to measure the quality of care unfairly penalize providers caring for patients with multiple chronic conditions. We therefore sought to study the relationship between the quality of care and the number of medical conditions a patient has. **Methods** We assessed measurements of the quality of medical care received in three cohorts of community-dwelling adult patients in the Community Quality Index study, the Assessing Care of Vulnerable Elders study, and the Veterans Health Administration project (7680 patients in total). We analyzed the relationship between the quality of care that patients received, defined as the percentage of quality indicators satisfied among those for which patients were eligible, and the number of chronic medical conditions each patient had. We further explored the roles of characteristics of patients, use of health care (number of office visits and hospitalizations), and care provided by specialists as explanations for the observed relationship. **Results** The quality of care increased as the number of medical conditions increased. Each additional condition was associated with an increase in the quality score of 2.2% (95% confidence interval [CI], 1.7 to 2.7) in the Community Quality Index cohort, of 1.7% (95% CI, 1.1 to 2.4) in the Assessing Care of Vulnerable Elders cohort, and of 1.7% (95% CI, 0.7 to 2.8) in the Veterans Health Administration cohort. The relationship between the quality of care and the number of conditions was little affected by adjustment for the difficulty of delivering the care recommended in a quality indicator and for the fact that, because of multiple conditions requiring the same care, a patient could be eligible to receive the same care process more than once. Adjustment for characteristics of patients, use of health care, and care provided by specialists diminished the relationship, but it remained positive.

**Lilford R, et al. Inter-rater reliability of case-note audit: a systematic review. *Journal of Health Services Research and Policy* 2007;12 (3) :173-80. DOI: 10.1258/135581907781543012**

Objective: The quality of clinical care is often assessed by retrospective examination of case-notes (charts, medical records). Our objective was to determine the inter-rater reliability of case-note audit. Methods: We conducted a systematic review of the inter-rater reliability of case-note audit. Analysis was restricted to 26 papers reporting comparisons of two or three raters making independent judgements about the quality of care. Results: Sixty-six separate comparisons were possible, since some papers reported more than one measurement of reliability. Mean kappa values ranged from 0.32 to 0.70. These may be inflated due to publication bias. Measured reliabilities were found to be higher for case-note reviews based on explicit, as opposed to implicit, criteria and for reviews that focused on outcome (including adverse effects) rather than process errors. We found an association between kappa and the prevalence of errors (poor quality care), suggesting alternatives such as tetrachoric and polychoric correlation coefficients be considered to assess inter-rater reliability. Conclusions: Comparative studies should take into account the relationship between kappa and the prevalence of the events being measured

**Lovett J, Curry A. Quality improvement with the new general practitioner contract - myth or reality? *Health Services Management Research* 2007;20 (2) :121-33. DOI: 10.1258/095148407780744633**

The introduction of the new general practitioner (GP) contract has been a significant development in the management of primary care and requires a number of changes to be made to the way things are done. This paper provides an initial evaluation of the impacts of the new contract from the perspective of practising GPs in the Greater Glasgow area of Scotland. Its impact is assessed using Ovretveit's three dimensions of quality: professional, client and managerial quality. Some of the changes have proved so far to have positive effects and some may prove to be increasingly negative if appropriate amendments to the contract are not realized. There are some noteworthy implications for policy here

**Parish, J The Health Foundation's Engaging with Quality in Primary Care *Quality in Primary Care* 2007 15 (4) 241-346**

Over 80% of contact between the public and the health service takes place in primary care settings. However, as with other areas of health care, there is a gap between known best practice and everyday care. In March 2007, The Health Foundation announced the winners of its £5.5 million Engaging with Quality in Primary Care scheme. Over the next three years, nine project teams will work to engage primary care clinicians in the quality improvement process and, by doing so, increase capacity for improvements in clinical quality in primary care in the UK.

**Veldhuijzen W, et al Characteristics of communication guidelines that facilitate or impede guideline use: a focus group study BMC Family Practice 2007 ;8:31. DOI 10.1186/1471-2296-8-31**

Background: The quality of doctor-patient communication has a major impact on the quality of medical care. Communication guidelines define best practices for doctor patient communication and are therefore an important tool for improving communication. However, adherence to communication guidelines remains low, despite doctors participating in intensive communication skill training. Implementation research shows that adherence is higher for guidelines in general that are user centred and feasible, which implies that they are consistent with users' opinions, tap into users' existing skills and fit into existing routines. Developers of communication guidelines seem to have been somewhat negligent with regard to user preferences and guideline feasibility. In order to promote the development of user centred and practicable communication guidelines, we elicited user preferences and identified which guideline characteristics facilitate or impede guideline use. Methods: Seven focus group interviews were conducted with experienced GPs, communication trainers (GPs and behavioural scientists) and communication learners (GP trainees and medical students) and three focus group interviews with groups of GP trainees only. All interviews were transcribed and analysed qualitatively. Results: The participants identified more impeding guideline characteristics than facilitating ones. The most important impeding characteristic was that guidelines do not easily fit into GPs' day-to-day practice. This is due to rigidity and inefficiency of communication guidelines and erroneous assumptions underpinning guideline development. The most important facilitating characteristic was guideline structure. Guidelines that were structured in distinct phases helped users to remain in control of consultations, which was especially useful in complicated consultations. Conclusion: Although communication guidelines are generally considered useful, especially for structuring consultations, their usefulness is impaired by lack of flexibility and applicability to practice routines. User centred and feasible guidelines should combine the advantages of helping doctors to structure consultations with flexibility to tailor communication strategies to specific contexts and situations

**Wray S. Health, Exercise, and Well-Being: The Experiences of Midlife Women from Diverse Ethnic Backgrounds. *Social Theory & Health* 2007; 5 :126-44. DOI: doi:10.1057/palgrave.sth.8700100**

This paper examines midlife women's experiences of exercise and health promotion initiatives and whether they contribute to health and well-being. A theme of the paper is the exploration of previous ways in which well-being has been conceptualised and constructed, including ways of measuring it. The paper argues that these ways of seeing well-being have been dominated by psychological and physiological concerns, and neglected well-being as a socially located phenomenon. The role of agency and individualistic emphasis on self as the agent of change are also explored. The paper

draws on qualitative research and has 3 aims: 1. Examine current perspectives on well-being 2. Consider the extent to which health promotion advice contributes to well-being 3. Examine perceptions and experiences of these initiatives across ethnically-diverse women

## RESEARCH AND DEVELOPMENT

**Allen P, et al. Commissioning research that is used: the experience of the NHS Service Delivery and Organisation Research and Development Programme. *Evidence & Policy* 2007;3: (1) 119-34. DOI: 10.1332/17442640779702193**

This article discusses the experiences of the NHS Service Delivery and Organisation Research and Development Programme (the SDO) in transferring knowledge from research into practice. In the context of relevant theories, four main difficulties in achieving knowledge transfer are described and two modes of knowledge production are uncovered: one being discipline based, and the other valuing research for its usefulness. In attempting to hold a balance between the two modes, the article shows how the SDO has dealt with the difficulties in knowledge transfer and concludes that a key to successful knowledge transfer is to achieve significant interaction between decision makers and research commissioners at the earliest possible stage.

**Chew-Graham C. Achieving target recruitment in a primary care trial: lessons from PRIDE. *Primary Health Care Research and Development* 2007;8:0 (3) 264-70. DOI: 10.1017/S146342360700031X,**

Background: Failure to reach recruitment targets is a widespread problem in RCTs (randomized controlled trials). This paper presents experience of recruiting patients into the PRIDE trial which was carried out in one Primary Care Trust (PCT) in the North West of England. Aim: The aim of this feasibility study was to test the effectiveness of a new model of care for the management of late-life depression. Method: GPs (general practitioners), PNs (practice nurses) and community nurses were invited to refer patients into the study. Over 100 patients were needed (at least 50 in each arm of the trial) for the study to be sufficiently powered. On-target recruitment of over 100 patients over 18 months was achieved. Findings: Data obtained from conversations and from semi-structured interviews with health professionals is presented to give possible explanations for this successful recruitment. Not all practices in the PCT engaged with the study, and the most common reasons given by GPs and their staff for non-participation was being single handed or already having a heavy work-load. All community nurses spoken to agreed to refer patients to the study but only five referrals were made by this group over the course of the study. The main reasons primary care professionals did agree to participate and continue to refer patients was that they felt the trial was offering a local and relevant service to an under-served patient group. The very simple referral process was also an important factor. In addition, the Trial Nurse was perceived to be responsive,

responding quickly to referrals made and providing regular and detailed feedback which was perceived to help and support the health professionals in the future management of the patient.

**Fransen GA, et al. Pragmatic trials in primary care. Methodological challenges and solutions demonstrated by the DIAMOND-study. *BMC.Medical Research Methodology* 2007; 7 :16. DOI: 10.1186/1471-2288-7-16**

Background: Pragmatic randomised controlled trials are often used in primary care to evaluate the effect of a treatment strategy. In these trials it is difficult to achieve both high internal validity and high generalisability. This article will discuss several methodological challenges in designing and conducting a pragmatic primary care based randomised controlled trial, based on our experiences in the DIAMOND-study and will discuss the rationale behind the choices we made. From the successes as well as the problems we experienced the quality of future pragmatic trials may benefit. Discussion: The first challenge concerned choosing the clinically most relevant interventions to compare and enable blinded comparison, since two interventions had very different appearances. By adding treatment steps to one treatment arm and adding placebo to both treatment arms both internal and external validity were optimized. Nevertheless, although blinding is essential for a high internal validity, it should be warily considered in a pragmatic trial because it decreases external validity. Choosing and recruiting a representative selection of participants was the second challenge. We succeeded in retrieving a representative relatively large patient sample by carefully choosing (few) inclusion and exclusion criteria, by random selection, by paying much attention to participant recruitment and taking the participant's reasons to participate into account. Good and regular contact with the GPs and patients was to our opinion essential. The third challenge was to choose the primary outcome, which needed to reflect effectiveness of the treatment in every day practice. We also designed our protocol to follow every day practice as much as possible, although standardized treatment is usually preferred in trials. The aim of this was our fourth challenge: to limit the number of protocol deviations and increase external validity. Summary: It is challenging to design and conduct a pragmatic trial. Thanks to thorough preparation, we were able to collect highly valid data. To our opinion, a critical deliberation of where on the pragmatic--explanatory spectrum you want your trial to be on forehand, in combination with consulting publications especially on patient recruitment procedures, has been helpful in conducting a successful trial

**Morgan PA, McCourt CA, Youll P. Social richness, socio-technical tension and the virtual commissioning of NHS research. *Health Research Policy and Systems* 2007;5:8. DOI: 10.1186/1478-4505-5-8**

- :: Background: This paper draws on a recent study that evaluated the process of commissioning NHS funded research using virtual committees. Building on an earlier paper that reported our evaluation, here we focus on the effects of asynchronous computer mediated communication (CMC) when used to support group work. Methods:

To do this the discussion focuses on how CMC affected three key group factors, building relationships, group cohesion and group commitment. The notion of socio-technical tension is elaborated and the paper explores how social richness can act to counter the socially impoverishing and time extending effects of asynchronous CMC. Results: We argue that social richness in this context results from the presence of five principal influences. These are: a dynamic range of participant aspirations and personal agendas; participant commitment to and identification with the work and ideals of the group; a rich diversity of social, professional and work-related backgrounds; a website designed to enhance participation and interaction and the mediating effects of an effective chairperson. Conclusion: If virtual work groups are to be used by the NHS in the future, then there is a need for more research into the role of social context and its relationship to the effectiveness of newly formed virtual groups. Equally as important are studies that examine the effects of socio-technical interaction on groups undertaking tasks in the real world of work

**Rahman A. Why do collaborative research? *British Medical Journal* 11/8/2007;335: 7614 304- . DOI: 10.1136/bmj.39297.500544.94**

Much of the most valuable medical research is done by large teams of people, often collaborating across several centres. Examples include randomised controlled trials that prove the efficacy of new forms of treatment and genetic studies that use clinical data from many hospitals to establish the linkage of genes to specific diseases. Such collaborative efforts are undervalued by academic institutions, to the extent that it could be argued that clinical academics who wish to thrive should avoid taking part in such collaborations—unless they are a lead author. Without colleagues who are prepared to collaborate without gaining the kudos of leading, however, none of these studies could be done. Are the disincentives to collaboration worse than before? One disincentive is the increasing complexity of documentation that researchers need to carry out any form of study involving patients. A researcher who signs up to recruit patients into any multicentre project—even if only blood samples are needed, or a review of case notes—will have to submit several forms to the local ethics committee and may have to deal with the research and development departments of several trusts. All of this may require hours of work spread over several months before the research can even begin.

**Reed DA, et al . Association between funding and quality of published medical education research. *Journal of the American Medical Association* 5<sup>th</sup> September 2007 298 (9) :1002-9.**

Context: Methodological shortcomings in medical education research are often attributed to insufficient funding, yet an association between funding and study quality has not been established. ObjectiveS: To develop and evaluate an instrument for measuring the quality of education research studies and to assess the relationship between funding and study quality. Design, setting, and participants: Internal consistency, interrater and intrarater reliability, and criterion validity were determined for a 10-item medical education research study quality instrument (MERSQI). This was applied to 210 medical education research studies published in 13 peer-reviewed journals between September 1, 2002, and

December 31, 2003. The amount of funding obtained per study and the publication record of the first author were determined by survey. MAIN Outcome measures: Study quality as measured by the MERSQI (potential maximum total score, 18; maximum domain score, 3), amount of funding per study, and previous publications by the first author. Results: The mean MERSQI score was 9.95 (SD, 2.34; range, 5-16). Mean domain scores were highest for data analysis (2.58) and lowest for validity (0.69). Intraclass correlation coefficient ranges for interrater and intrarater reliability were 0.72 to 0.98 and 0.78 to 0.998, respectively. Total MERSQI scores were associated with expert quality ratings (Spearman rho, 0.73; 95% confidence interval [CI], 0.56-0.84;  $P < .001$ ), 3-year citation rate (0.8 increase in score per 10 citations; 95% CI, 0.03-1.30;  $P = .003$ ), and journal impact factor (1.0 increase in score per 6-unit increase in impact factor; 95% CI, 0.34-1.56;  $P = .003$ ). In multivariate analysis, MERSQI scores were independently associated with study funding of \$20 000 or more (0.95 increase in score; 95% CI, 0.22-1.86;  $P = .045$ ) and previous medical education publications by the first author (1.07 increase in score per 20 publications; 95% CI, 0.15-2.23;  $P = .047$ ). CONCLUSION: The quality of published medical education research is associated with study funding

**Salmon P, Peters S, Rogers A, Gask L, Clifford R, Iredale W *et al.* Peering through the barriers in GPs' explanations for declining to participate in research: the role of professional autonomy and the economy of time. *Family Practice* . 2007;24: (3) 269-75.**

Background: The level of participation in research by GPs is low internationally. Previous reports of the reasons why practitioners decline opportunities for research participation have tended to recount the barriers that they describe as if they are objective accounts. Objective: By theoretical sampling of practitioners who had declined to participate in a research trial, we sought to interpret the functional significance and interrelationship of the barriers that they reported. MethodS: Twenty-three GPs who had declined to participate in a trial of training to manage medically unexplained symptoms were interviewed and their accounts analysed interpretatively. Results: The practitioners described general practice and research as alien fields. Research lacked intrinsic, clinical or professional value and was linked to evidence-based medicine which they rejected as incompatible with person-centered care. Every doctor described a lack of time for research, but time was an elastic resource that payment could release from the reservoir of their 'own time'. Conclusion: The findings should inform the design and interpretation of future quantitative surveys to identify how common the attitudes that we report are. Doctors with the attitudes of those whom we interviewed will not be drawn into research by measures predicated on the assumption that it is intrinsically, clinically or professionally valuable. If they cannot be convinced of its utility, value could be conferred by payment for participation

## RESEARCH GOVERNANCE

Colquhoun, David. How to get good science. *DC's Improbable Science* . 2007. 13-8-2007. <http://www.dscience.net/goodscience/?p=4>

The aim of this article is to consider how a university can achieve the best research and teaching, and the most efficient administration.

## RESEARCH METHODS

Featherstone V, Barbour R S, Garner J. A reflection on ten years experience of providing qualitative research training in primary care. *Primary Health Care Research and Development* 2007; 8 (3) 198-206. DOI: 10.1017/S1463423607000242

Aims: To gain structured feedback on a qualitative research methods training programme delivered to primary care researchers over a period of ten years. To examine dilemmas and challenges and how these had been resolved. To examine how the programme could be further developed. Background: The Wolds Primary Care Research Network's (WoReN) qualitative research methods training programme was developed and evolved in response to the needs of primary care practitioners and researchers and the NHS Research Agenda. Methods: Information on participants' professional backgrounds; which workshops they attended; their evaluation sheets, comments; and personal appraisals were collected from 1996 to 2006. Structured telephone conversations with a number of participants and ongoing informal feedback from participants added to this information. Numbers and ranges of professionals attending workshops were ascertained, how far they travelled to workshops and further degrees obtained by them, within the decade, were also noted. Findings: We found a lack of similar training elsewhere. A wide range of people attended workshops, especially general practitioners (GP) and academic researchers. Other practitioners were a significant presence however, and included nurses, pharmacists, health visitors and professions allied to medicine. Participants were prepared to attend extended workshops and to travel significant distances to them. Participants preferred a continuous cycle of workshops rather than discreet sessions, in order for them to consolidate their learning and to develop at their own pace. Practical exercises reflecting the qualitative research process were considered very conducive to learning and participants also appreciated one-to-one consultations about their work and longer-term, ongoing support as they progressed through their projects. Workshop design needed to continually reflect the changing requirements of participants, employers, funders, potential trainers and national NHS requirements. A

new audience for training was identified in supervisors not versed in the qualitative paradigm.

**Lewis S. Toward a general theory of indifference to research-based evidence.**  
*Journal of Health Services Research and Policy* 2007;12 (3) 166-72. DOI:  
10.1258/135581907781543094

Evidence-based medicine (EBM) and evidence-based decision-making (EBDM) were intended to revolutionize health care and health policy. Thus far they have not. A great deal of research has demonstrated the persistent ubiquity of error in health care, wide and unjustifiable variations in practice and the minimal impact of decision aids such as clinical practice guidelines. This paper attempts to explain why EBM and EBDM have remained largely unrealized ambitions. It advances 10 propositions that together constitute a general theory of indifference to research-based evidence. Some of these propositions are conceptual (e.g. the epistemic resistance to the randomized trial), some are empirical (e.g. the impact of the corruption of science by industry), some are cognitive (e.g. human problems are holistic while science is typically fragmented and narrative free) and some are normative (e.g. the primary goal is not adherence to methods, but to make better decisions with better outcomes, irrespective of their origins). EBM and EBDM over-reached, and their failure was, as a consequence, inevitable. However, with corrective action on a number of fronts, research-based evidence can and should be more influential. The first step is to reconceive EBM and EBDM as habits of mind rather than a toolbox and to recognize that the sociology of knowledge is as important as its technical content

**Murchie P et al Designing an integrated follow-up programme for people treated for cutaneous malignant melanoma: a practical application of the MRC framework for the design and evaluation of complex interventions to improve health** *Family Practice* 2007 24(3) 283-292

Background: Complex health care interventions are difficult to design and evaluate, so the UK Medical Research Council (MRC) has developed a 'framework for the design and evaluation of complex health care intervention'. Researchers differ in applying the framework. Objective: To describe and critically evaluate how the two initial phases of the MRC framework facilitate the design of an integrated follow-up programme for cutaneous melanoma to a standard suitable for testing in an exploratory randomized trial. Design of study. Literature review, expert groups, semi-structured interviews and pilot exercise to develop an intervention. Setting: A department of academic primary care. Two general practices. Methods: Four techniques were used-iterative literature review, a steering group, semi-structured telephone interviews and an operationalization exercise. These techniques were used simultaneously and iteratively to complete the theoretical preclinical and phase I modelling of the MRC framework when developing an integrated follow-up programme for cutaneous melanoma. Results: Components of an integrated follow-up programme for cutaneous malignant melanoma were identified, developed and refined into a practical intervention comprising GP training; structured protocol-driven appointments; a centralized recall system; a rapid access pathway and a patient information booklet. Several barriers that could have derailed the successful

implementation of the intervention, including the different perspectives of stakeholders and resource needs in general practice were identified. The value of the principles of the initial two phases of the MRC framework in guiding the development of complex health care interventions was supported. Conclusions: We recommend that the first two phases of the MRC framework be used iteratively and simultaneously when developing complex health care interventions

**Murtagh MJ, et al. Qualitative methods in a randomised controlled trial: the role of an integrated qualitative process evaluation in providing evidence to discontinue the intervention in one arm of a trial of a decision support tool. *Quality and Safety in Health Care* 2007;16 (3) 224-9. DOI: 10.1136/qshc.2006.018499**

Objective: To understand participants' experiences and understandings of the interventions in the trial of a computerised decision support tool in patients with atrial fibrillation being considered for anti-coagulation treatment. Design: Qualitative process evaluation carried out alongside the trial: non-participant observation and semistructured interviews. Participants: 30 participants aged >60 years taking part in the trial of a computerised decision support tool. Results: Qualitative evidence provided the rationale to undertake a decision to discontinue one arm of the trial on the basis that the intervention in that arm, a standard gamble values elicitation exercise was causing confusion and was unlikely to produce valid data on participant values. Conclusions: Qualitative methods used alongside a trial allow an understanding of the process and progress of a trial, and provide evidence to intervene in the trial if necessary, including evidence for the rationale to discontinue an intervention arm of the trial

**Shortell SM, Rundall TG, Hsu J. Improving patient care by linking evidence-based medicine and evidence-based management. *Journal of the American Medical Association* 8/9/2007; 298 (6) :673-6.**

Not until about 100 years ago could a typical patient expect to benefit from the medical care provided by a typical physician. Today most patients benefit from medical care, but all patients could benefit more if clinicians routinely provided care consistent with the latest scientific knowledge. One report suggests that only 55% of US adults receive care consistent with current recommendations. In 2001, the Institute of Medicine concluded that a chasm lies "between the healthcare we have and the healthcare we should have."<sup>2</sup> Moreover, the results of efforts to improve medical quality have been modest and uneven to date.

## SERVICE ORGANISATION AND DELIVERY

**Alazri M, Heywood P, Leese B. How do receptionists view continuity of care and access in general practice? *European Journal of General Practice*. 2007;13 (2) 75-82. DOI: 10.1080/13814780701379048**

Background: Continuity of care is widely regarded as an important feature of general practice, but the role of receptionists in influencing continuity has been the subject of little research. Objective: To explore how receptionists might influence access and continuity of care in general practice. Methods: A questionnaire survey of receptionists in practices in Leeds, UK, was conducted. All 119 practices in Leeds were contacted to recruit receptionists via practice managers. A total of 148 receptionists responded from 50 practices. Results: The majority of receptionists (140, 94%) perceived continuity as team continuity. Most (139, 93%) felt it was important for the patient to be seen on the same day by any doctor, rather than the usual doctor. They were less willing to ask patients for more details of a routine problem than an urgent one. The majority (113, 76%) thought that non-attendance was more related to patient issues than to their own behaviour. Organizational factors affected how receptionists offered appointments. Advanced access could impede longitudinal continuity and, indirectly, relational continuity. Having a policy to deal with urgent appointments or routine appointments could facilitate such continuity. Conclusion: The majority of receptionists perceived continuity as a team response rather than longitudinal. However, if relational continuity is to survive in UK and European general practice, educational and training measures would need to be taken to promote these values to receptionists

**Bindman A B, et al. Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand, and the United States: cross sectional analysis of results from three national surveys. *British Medical Journal* 16/6/ 2007; 334:7606 1261-4. DOI: 10.1136/bmj.39203.658970.55**

Objectives: To compare mix of patients, scope of practice, and duration of visit in primary care physicians in Australia, New Zealand, and the United States. Design: Comparison of three comparable cross sectional surveys performed in 2001-2. Physicians completed a questionnaire on patients' demographics, diagnoses, and duration of visit. Setting: Primary care practice. Participants: 79,790 office visits in Australia, 10,064 in New Zealand, and 25,838 in the US. Main outcome measures: Diagnostic codes were mapped to the Johns Hopkins expanded diagnostic clusters. Scope of practice was defined as the number of expanded diagnostic clusters accounting for 75% of all managed problems related to morbidity. Exposure to primary care was calculated from duration of visits recorded by the physician, and reports on rates of visits to primary care for each country. Results: In each country, primary care physicians managed an average of 1.4 morbidity related problems per visit. In the US, 46 expanded diagnostic clusters

accounted for 75% of problems managed compared with 52 in Australia, and 57 in New Zealand. Correlations in the frequencies of managed health problems between countries were high (0.87-0.97 for pairwise comparisons). Though primary care visits were longer in the US than in New Zealand and Australia, the per capita annual exposure to primary care physicians in the US (29.7 minutes) was about half of that in New Zealand (55.5 minutes) and about a third of that in Australia (83.4 minutes) because of higher rates of visits to primary care in these countries. Conclusions: Despite differences in the supply and financing of primary care across countries, many aspects of the clinical practice of primary care physicians are remarkably similar in Australia, New Zealand, and the US.

**Dobscha S K, et al. Primary care provider preferences for working with a collaborative support team. *Implementation Science* 2007 2:16 31/5/2007 DOI: doi:10.1186/1748-5908-2-16**

**Background** Clinical interventions based on collaborative models require effective communication between primary care providers (PCPs) and collaborative support teams. Despite growing interest in collaborative care, we have identified no published studies describing how PCPs prefer to communicate and interact with collaborative support teams. This manuscript examines the communication and interaction preferences of PCPs participating in an ongoing randomized clinical trial of a collaborative intervention for chronic pain and depression. **Methods** The trial is being conducted in five primary care clinics of a Veterans Affairs Medical Center. Twenty-one PCPs randomized to the study intervention completed a survey regarding preferences for interacting with the collaborative support team. **Results** A majority of PCPs identified email (95%) and telephone calls (68%) as preferred modes for communicating with members of the support team. In contrast, only 29% identified in-person communications as preferred. Most PCPs preferred that the care manager and physician pain specialist assess patients (76%) and make initial treatment changes (71%) without first conferring with the PCP. One-half wanted to be designated cosigners of all support team notes in the electronic medical record, one-half wanted to receive brief and focused information rather than in-depth information about their patients, and one-half wanted their practice nurses automatically included in communications. Panel size was strongly associated ( $p < 0.001$ ) with preference for brief, to-the-point discussions about patients. **Conclusion** The substantial variation in PCP communication preferences suggests the need for knowledge of these preferences when designing and implementing collaborative interventions. Additional research is needed to understand relationships between clinician and practice characteristics and interaction preferences.

**Saxena S, et al Practice size, caseload, deprivation and quality of care of patients with coronary heart disease, hypertension and stroke in primary care: national cross-sectional study. *BMC Health Services Research* 2007;7 :96. DOI: 10.1186/1472-6963-7-96**

Background: Reports of higher quality care by higher-volume secondary care providers have fuelled a shift of services from smaller provider units to larger hospitals and units. In the United Kingdom, most patients are managed in primary care. Hence if larger practices provide better quality of care; this would have important implications for the future organization of primary care services. We examined the association between quality of primary care for cardiovascular disease achieved by general practices in England and Scotland by general practice caseload, practice size and area based deprivation measures, using data from the New General Practitioner (GP) Contract. Methods: We analyzed data from 8,970 general practices with a total registered population of 55,522,778 patients in England and Scotland. We measured practice performance against 26 cardiovascular disease (coronary heart disease, left ventricular disease, and stroke) Quality and Outcomes Framework (QOF) indicators for patients on cardiovascular disease registers and linked this with data on practice characteristics and census data. Results: Despite wide variations in practice list sizes and deprivation, the prevalence of was remarkably consistent, (coronary heart disease, left ventricular dysfunction, hypertension and cerebrovascular disease was 3.7%; 0.45%; 11.4% and 1.5% respectively). Achievement in quality of care for cardiovascular disease, as measured by QOF, was consistently high regardless of caseload or size with a few notable exceptions: practices with larger list sizes, higher cardiovascular disease caseloads and those in affluent areas had higher achievement of indicators requiring referral for further investigation. For example, small practices achieved lower scores 71.4% than large practices 88.6% ( $P < 0.0001$ ) for referral for exercise testing and specialist assessment of patients with newly diagnosed angina. Conclusion: The volume-outcome relationship found in hospital settings is not seen between practices in the UK in management of cardiovascular disorders in primary care. Further work is warranted to explain apparently poorer quality achievement in some aspects of cardiovascular management relating to initial diagnosis and management among practices in deprived areas, smaller practices and those with a smaller caseload

**Scott K, et al . Confidentiality in the waiting room: an observational study in general practice. *British Journal of General Practice* 2007; 57:539 490-3.**

An ethnographic study using overt non-participatory observation was used to investigate confidentiality breaches in 13 GP practice reception and/or waiting areas in Lincolnshire. Staff and patient behaviours were observed for 2 hours. Aspects of management systems and physical environment were also thematically analysed. Forty-four instances occurred where patient-identifiable information was overheard. Of these instances, 22 were initiated by staff, 22 by patients, 33 face-to-face, and 10 from telephone conversations. Breaches included name and address, symptoms, conditions, or test results. Interaction between systems and physical environment in relation to 'attention focus', 'sound' and 'layout', increased the likelihood of breach of confidentiality. Further research on the patient perspective is recommended

## WORKFORCE

**Bamford D, Hall C. A case study into labour turnover within an NHS Trust. *Health Services Management Research* 2007; 20 (1) 9-21. DOI: 10.1258/095148407779615007**

This paper investigates turnover in a British NHS Trust, to find out why staff left and whether factors identified in the literature with regards to improving turnover were pertinent to the organization. The research also investigated staff groups with high turnover--staff with less than 12 months service, and the unqualified nursing staff group--to ascertain whether there were any reasons for leaving or areas of dissatisfaction particular to these groups. The outcomes of the research complied with much of the published research with some interesting differences. The main reasons for leaving were identified as moving house, promotion or career development and taking up education and training opportunities elsewhere. There was no evidence of 'level of pay', commonly given as a significant influence behind turnover, as a reason for leaving. It was also found that the retention strategies identified in the published research were mainly applicable to the research, with evidence to support the improvement of line management skills, training and development, career development, appraisal, communications and induction in order to reduce turnover. There was less evidence for introducing work-life balance policies, improving communications, pay and working relationships as retention strategies. Recommendations for future management of labour turnover within the NHS Trust and elsewhere are made, with observations about the validity of some existing models. The core contribution of this research is in adding to the body of knowledge about labour turnover issues. This is of value to those working in the UK health-care and wider public sector. Specific recommendations for future research are made

**Bayram C et al . Clinical activity of overseas-trained doctors practising in general practice in Australia *Australian Health Review* . 2007;31 (3) 440-8.**

Introduction: Medical workforce shortages in Australia have led to increasing reliance on overseas-trained doctors (OTDs) to work in general practice in areas of need, particularly in rural areas. These OTDs do not have Australian postgraduate training in general practice, and we know little about how they practise. Objective: To determine differences in practice style between a self-selected group of overseas-trained general practitioners undertaking the Alternative Pathways Program and GPs who are Fellows of the Royal Australian College of General Practitioners (FRACGP), and whether such differences can be explained by other practitioner, practice and patient characteristics. Method: A self-selected sample of 89 OTDs from the Alternative Pathways Program were compared with FRACGPs in a continuous national study of GP activity (n = 1032). Each GP provided details about themselves and their practice and recorded data about patients, morbidity and treatments for 100 encounters. Results: OTDs were younger, less experienced, worked more sessions per week, in smaller practices. OTDs saw fewer children and

elderly patients, more new patients, health concession card holders and Indigenous people. OTDs managed less general, urological, social, skin and pregnancy problems, and more cardiovascular problems, urinary tract infections, tonsillitis and conjunctivitis. They provided more medications, other treatments and referrals, and ordered more pathology and imaging tests. Conclusion: This study suggests that OTDs see a different patient mix and range of morbidity and provide different management to that of FRACGPs, generating higher costs of care. Regular study of the clinical activities of a representative sample of overseas-trained GPs is needed

**Brooks F, et al. The school nurse as navigator of the school health journey: developing the theory and evidence for policy. *Primary Health Care Research and Development* 2007; 8 (3) 226-34. DOI: 10.1017/S1463423607000278**

The aim of this article is to explore how the development of the theoretical and strategic basis of school nursing offers a vehicle for the delivery of an effective public health strategy for children and adolescents. Through a critical examination of the status and scope of school nursing within the UK and US health care systems it is clear that a deficiency exists regarding the theoretical and strategic basis for the functioning of school nursing. Consideration is given to the concept of the school nurse as ‘navigator’ for the child along the trajectory of the school health journey. This novel approach to school nursing needs to be developed theoretically and evaluated for effectiveness. A rapid review of the evidence to support school nursing interventions has revealed that the evidence base for school nursing interventions/actions remains very weak, thereby challenging the ability of school nurses to deliver desired outcomes for the present ambitious public health agenda. We argue that a planned approach to developing the evidence for school nursing, based on the UK Medical Research Council (MRC, 2000) framework for the evaluation of complex interventions, could help to ensure a robust role for the school nurse. This acknowledgement and development of a novel approach to school nursing could contribute to policy implementation around public health goals for the school-aged population.

**Buetow S. What motivates health professionals? Opportunities to gain greater insight from theory. *Journal of Health Services Research and Policy* 2007;12 (3) :183-5. DOI: 10.1258/135581907781543111**

Abstract: Health care policy-makers and researchers need to pay more attention to understanding the influence of motivation on professional behaviour. Goal setting theory, including two hypotheses - the business case and the pride case - dominates current attempts to motivate professionals. However, the predominance of goal setting theory stifles other approaches to conceptualizing professional motivation. These approaches include other cognitive theories of motivation, such as self-determination theory (concerned with how to use extrinsic rewards that enhance intrinsic motivation), as well as content, psychoanalytic and environmental theories. A valuable opportunity exists to develop and test such theories in addition to possible hybrids, for example, by elaborating

goal setting theory in health care. The results can be expected to inform health policy and motivate individual professionals, groups, organizations and workforces to improve and deliver high quality care

**Coombs CR, Arnold J, Loan-Clarke J, Wilkinson A, Park J, Preston D. Improving the recruitment and return of nurses and allied health professionals: a quantitative study. *Health Services Management Research* 2007;20 (1) 22-36. DOI: 10.1258/095148407779614972**

The United Kingdom National Health Service (NHS) is continuing to experience recruitment and retention problems of nursing and allied health profession staff. Consequently, the need to study and understand the key factors that encourage or dissuade people to work for the NHS remains a major research and policy issue. This study provides well-focused, independent research to explore how the NHS can be made more attractive for potential new recruits and possible returners. The views of potential recruits and returners interested in working for the NHS as either a qualified nurse, physiotherapist or radiographer were explored through a postal questionnaire survey which achieved a response rate of 23%. Analysis of the results indicate that the strongest predictor of intention to work for the NHS in one of the three professions was the attitude held by respondents. These attitudes in turn were most influenced by the extent to which people perceived that NHS work as a qualified nurse, physiotherapist or radiographer offered positive features, i.e. rewarding career, teamwork and a chance to help people and to get to know them. The views of family and friends regarding working for the NHS were also important as was the belief in one's ability to secure an NHS job

**Fielden S, Whiting F. The psychological contract: is the UK National Health Service a model employer? *Health Services Management Research* 2007;20 (2) 94-104. DOI: 10.1258/095148407780744642**

The UK National Health Service (NHS) is facing recruitment challenges that mean it will need to become an 'employer of choice' if it is to continue to attract high-quality employees. This paper reports the findings from a study focusing on allied health professional staff (n = 67), aimed at establishing the expectations of the NHS inherent in their current psychological contract and to consider whether the government's drive to make the NHS a model employer meets those expectations. The findings show that the most important aspects of the psychological contract were relational and based on the investment made in the employment relationship by both parties. The employment relationship was one of high involvement but also one where transactional contract items, such as pay, were still of some importance. Although the degree of employee satisfaction with the relational content of the psychological contract was relatively positive, there was, nevertheless, a mismatch between levels of importance placed on such aspects of the contract and levels of satisfaction, with employees increasingly placing greater emphasis on those items the NHS is having the greatest difficulty providing. Despite this apparent disparity between employee expectation and the fulfilment of those expectations, the overall health of the psychological contract was still high

**McIlfatrick S, et al. Managing chronic disease: a case study of an innovative role in respiratory nursing practice. *Primary Health Care Research and Development* 2007;8 (3):251-63. DOI: 10.1017/S1463423607000308**

- Background: The increased incidence of chronic disease in recent years represents a significant challenge for the National Health Service. This coupled with substantial reforms in recent years has resulted in many changes in the delivery of healthcare, such as the proliferation of new nursing and midwifery roles. One such role is the Respiratory Nurse Specialist. Aims: The aim of this paper is to explore the role of the RNS from the post-holder and service perspective. This includes examining the organizational infrastructure, working relationships, career paths, perceived benefits and enablers and barriers required to make this role successful. Methods: A naturalistic case study methodology was adopted and a variety of data collection approaches were used. These included semi-structured interviews with the post-holder, line manager and Director of Finance, non-participant observation of practice, review of job description, audit data and other relevant documentation relating to the post. Findings: Findings revealed evidence of the role being innovative and effective. These related to the role context; role delivery, skills and knowledge required; the personal characteristics of the post-holder, the impact on multidisciplinary integrated working and the response to the needs of patients and communities. Conclusions: This case study illustrates the value and potential of nurses to lead and co-ordinate the care for patients with chronic diseases, and specifically the provision of a high-quality respiratory service

**Serneels P,et al For public service or money: understanding geographical imbalances in the health workforce *Health Policy and Planning* 2007;22 (3) :128-38. DOI: 10.1093/heapol/czm005**

Geographical imbalances in the health workforce have been a consistent feature of nearly all health systems, and especially in developing countries. In this paper we investigate the willingness to work in a rural area among final year nursing and medical students in Ethiopia. Analysing data obtained from contingent valuation questions for final year students from three medical schools and eight nursing schools, we find that there is substantial heterogeneity in the willingness to serve in rural areas. Using both ordinary least squares and maximum likelihood regression analysis, we find that household consumption and the student's motivation to help the poor are the main determinants of willingness to work in a rural area. We carry out a simulation on how much it would cost to get a target proportion of health workers to take up a rural post

**Troy PH, et al Nurses' experiences of recruitment and migration from developing countries: a phenomenological approach. *Human Resources for Health* 2007;5:15. DOI: 10.1186/1478-4491-5-15**

Background: There is growing concern globally at the current flows of nurse migration, particularly from low-income to middle and high-income countries. Recruitment practices of many countries such as Ireland are thought to be fuelling this rate of migration. This paper aims to establish the perceptions and opinions of those involved in the recruitment process on their role in recruitment and the effects recruitment has on both source and destination countries. Methods: A purposive sample of 12 directors of nursing, from major academic teaching hospitals in Dublin and hospitals in South Africa and the Philippines were recruited. Ten overseas nurses were also recruited. A phenomenological approach was used with semi-structured interviews as the data collection method. Results: There were pronounced differences in opinions between the Irish and the overseas directors on recruitment and its effects on the health systems of the source countries. Difficulties in the retention of staff were highlighted by both groups of directors. Other findings included the language and cultural differences experienced by the overseas nurses. Conclusion: Recruitment of overseas nurses should not be left to the individual employer even in the presence of government guidelines. An international effort from all the involved parties is required to formulate a solution to this complex issue in order to protect both the health systems of individual countries and the nurse's right to migrate

**Weiner JP Expanding the US medical workforce: global perspectives and parallels. *British Medical Journal* 2007; 335:7613 236-8. DOI: 10.1136/bmj.39246.598345.94**

The American medical education community has reached a consensus that a shortage of doctors is looming. Several years of heated discourse, dominated by current and former medical school deans, culminated in an influential position paper by the American Association of Medical Colleges (AAMC) calling for an urgent and immediate expansion of US medical students by 30%. The arguments for expansion have been discussed fully elsewhere,<sup>2 3 4 5</sup> They include the belief that patients will soon want and need more services than the current stock of doctors can provide, newly trained doctors will be unwilling or unable to see as many patients each week as in the past, and the US should not be so reliant on doctors trained abroad. But is there really a problem?

**Zantinge E M, et al. The workload of general practitioners does not affect their awareness of patients' psychological problems. *Patient Education and Counseling* 2007; 67 1-2 93-9. DOI: doi:10.1016/j.pec.2007.02.006**

Objective To investigate if general practitioners (GPs) with a higher workload are less inclined to encourage their patients to disclose psychological problems, and are less aware of their patients' psychological problems. Methods Data from 2095 videotaped consultations from a representative selection of 142 Dutch GPs were used. Multilevel regression analyses were performed with the GPs' awareness of the patient's psychological problems and their communication as outcome measures, the GPs' workload as a predictor, and GP and patient characteristics as confounders. Results GPs'

workload is not related to their awareness of psychological problems and hardly related to their communication, except for the finding that a GP with a subjective experience of a lack of time is less patient-centred. Showing eye contact or empathy and asking questions about psychological or social topics are associated with more awareness of patients' psychological problems. Conclusion Patients' feelings of distress are more important for GPs' communication and their awareness of patients' psychological problems than a long patient list or busy moment of the day. GPs who encourage the patient to disclose their psychological problems are more aware of psychological problems. Practice implications We recommend that attention is given to all the communication skills required to discuss psychological problems, both in the consulting room and in GPs' training. Additionally, attention for gender differences and stress management is recommended in GPs' training.

