

NATIONAL PRIMARY CARE RESEARCH & DEVELOPMENT CENTRE

LIBRARY AND INFORMATION SERVICE

CURRENT AWARENESS BULLETIN

NOVEMBER - DECEMBER 2007



**NATIONAL
PRIMARY CARE
RESEARCH AND
DEVELOPMENT
CENTRE**

ACCESS TO CARE.....	3
CHRONIC ILLNESS	5
EVIDENCE BASED MEDICINE	12
HEALTH ECONOMICS	14
HEALTH INEQUALITIES	15
INFORMATION AND COMMUNICATION TECHNOLOGY IN HEALTH CARE	21
MEDICINES MANAGEMENT	22
MENTAL HEALTH.....	24
NEED AND DEMAND FOR CARE	28
ORGANISATIONS.....	29
PATIENT AND PUBLIC INVOLVEMENT	31
PRIMARY/SECONDARY CARE INTERFACE.....	33
QUALITY OF CARE	34
RESEARCH AND DEVELOPMENT	43
RESEARCH METHODS	44
SERVICE ORGANIZATION AND DELIVERY	45
WORKFORCE	45

As far as possible, a doi (digital object identifier) has been provided for each article. Provided one has the requisite subscribed or open access, the document can be found by entering the doi in <http://dx.doi.org>. These citations were retrieved from Pubmed.

ACCESS TO CARE

Devoe JE, et al Insurance + access != health care: typology of barriers to health care access for low-income families. *Annals of Family Medicine* 2007 5 (6) 511-8 DOI: 10.1370/afm.748

Purpose: Public health insurance programs have expanded coverage for the poor, and family physicians provide essential services to these vulnerable populations. Despite these efforts, many Americans do not have access to basic medical care. This study was designed to identify barriers faced by low-income parents when accessing health care for their children and how insurance status affects their reporting of these barriers. Methods: A mixed methods analysis was undertaken using 722 responses to an open-ended question on a health care access survey instrument that asked low-income Oregon families, "Is there anything else you would like to tell us?" Themes were identified using immersion/crystallization techniques. Pertinent demographic attributes were used to conduct matrix coded queries. Results: Families reported 3 major barriers: lack of insurance coverage, poor access to services, and unaffordable costs. Disproportionate reporting of these themes was most notable based on insurance status. A higher percentage of uninsured parents (87%) reported experiencing difficulties obtaining insurance coverage compared with 40% of those with insurance. Few of the uninsured expressed concerns about access to services or health care costs (19%). Access concerns were the most common among publicly insured families, and costs were more often mentioned by families with private insurance. Families made a clear distinction between insurance and access, and having one or both elements did not assure care. Our analyses uncovered a 3-part typology of barriers to health care for low-income families. Conclusions: Barriers to health care can be insurmountable for low-income families, even those with insurance coverage. Patients who do not seek care in a family medicine clinic are not necessarily getting their care elsewhere

Greenhalgh T, Voisey C, Robb N. Interpreted consultations as 'business as usual'? an analysis of organisational routines in general practices. *Sociology of Health and Illness* 2007 29 (6) 931-954 DOI: 10.1111/j.1467-9566.2007.01047.x

UK general practices operate in an environment of high linguistic diversity, because of recent large-scale immigration and of the NHS's commitment to provide a professional interpreter to any patient if needed. Much activity in general practice is co-ordinated and patterned into organisational routines (defined as repeated patterns of interdependent actions, involving multiple actors, bound by rules and customs) that tend to be stable and to persist. If we want to understand how general practices are responding to pressures to develop new routines, such as interpreted consultations, we need to understand how existing organisational routines change. This will then help us to address a second question, which is how the interpreted consultation itself is being enacted and changing

as it becomes routinised (or not) in everyday general practice. In seeking answers to these two questions, we undertook a qualitative study of narratives of interpreted primary care consultations in three London boroughs with large minority ethnic populations. In 69 individual interviews and two focus groups, we sought accounts of interpreted consultations from service users, professional interpreters, family member interpreters, general practitioners, practice nurses, receptionists, and practice managers. We asked participants to tell us both positive and negative stories of their experiences. We analysed these data by searching for instances of concepts relating to the organisational routine, the meaning of the interpreted consultation to the practice, and the sociology of medical work. Our findings identified a number of general properties of the interpreted consultation as an organisational routine, including the wide variation in the form of adoption, the stability of the routine, the adaptability of the routine, and the strength of the routine. Our second key finding was that this variation could be partly explained by characteristics of the practice as an organisation, especially whether it was traditional (small, family-run, 'personal' identity, typically multilingual, loose division of labour, relatively insular) or contemporary (large, bureaucratic, 'efficient' identity, typically monolingual, clear division of labour, richly networked). We conclude that there is a fruitful research agenda to be explored that links the organisational dimension of interpreting services with studies of clinical care and outcomes.

Lantz PM, Lichtenstein RL, Pollack HA. Health policy approaches to population health: the limits of medicalization. *Health Affairs (Millwood.)* 2007 26 (5) 1253-7 DOI: 10.1377/hlthaff.26.5.1253

Because of a strong tendency to "medicalize" health status problems and to assume that their primary solution involves medical care, policymakers often focus on increased financial and geographic access to personal health services in policies aimed at populations that are vulnerable to poor health. This approach has produced real public health gains, but it has neglected key social and economic causes of health vulnerability and disparities. Although access to care is a necessary component of population health, concerted policy action in income security, education, housing, nutrition/food security, and the environment is also critical in efforts to improve health among socially disadvantaged populations

Schoen C, et al Toward higher-performance health systems: adults' health care experiences in seven countries, 2007. *Health Affairs (Millwood.)* 2007 26 (6) w717-w734. DOI: 10.1377/hlthaff.26.6.w717

This 2007 survey compares adults' health care experiences in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. In all countries, the study finds that having a "medical home" that is accessible and helps coordinate care is associated with significantly more positive experiences. There were wide country differences in access, after-hours care, and coordination but also areas of shared concern. Patient-reported errors were high for those seeing multiple doctors or having multiple chronic illnesses. The United States stands out for cost-related access barriers and less-efficient care

Williamson M. Primary care for offenders: what are the issues and what is to be done? *Quality In Primary Care* 2007 15 (5) 301-6.

This paper outlines the health and social care needs of offenders and the challenges faced by those providing them with healthcare. It proposes a shared and dependant relationship between security, health and social care teams. A summary review of the literature in regard of what works is presented with a suggestion of the key learning points. The joint approach depends on shared values, shared principles, and a shared vision of what is needed and how it should be delivered. A model of service based on a key set of health and social care pathways is then described and an example of a care pathway, the integrated drug treatment strategy, is described in more detail. The broad approach is essential in meeting the moral imperative of improving the outcomes of offenders in relation to their health, social exclusion and life experiences.

Wilson A. Planning primary health-care services for South Australian young offenders: A preliminary study. *International Journal of Nursing Practice* 2007 13 (5) 296-303. DOI: 10.1111/j.1440-172X.2007.00641.x

Although many young offenders receive health care during periods of detention, addressing their health needs after release from secure care is a key strategy for successful rehabilitation and reintegration into the community. The purpose of this preliminary study was to examine current discharge planning practices for young offenders in Youth Training Centres in South Australia with a view to improving offenders' connection with primary health-care services on discharge. To determine the strengths and weaknesses of current discharge planning practices, this exploratory study involved in-depth review of literature and a semistructured focus group of stakeholders. Findings were discussed with an expert advisory group before final recommendations were made. This study identified a service model approach to discharge planning that recommended a nurse located within the Divisions of General Practice as the coordinator. The study found that trusted staff in detention centres, with an awareness of services available in the location of release, influence young offenders' decision-making in relation to health-care services. Awareness and recognition of young offenders' health beyond periods of juvenile detention and into their adult lives is valuable in that it has the potential to establish lifelong healthy behaviours. Bonding with young offenders and gaining their trust increases their likelihood of attending primary health-care services.

CHRONIC ILLNESS

Bartholomee Y, Maarse H. Empowering the chronically ill? Patient collectives in the new Dutch health insurance system. *Health Policy* 2007 84 (2-3) 162-9. DOI: 10.1016/j.healthpol.2007.03.008

On January 1, 2006, the Dutch government instituted major reforms to the country's health insurance scheme. One of the features of the new system is the opportunity for groups to form collectives that may negotiate and enter into group contracts with health insurers. This article discusses one particular type of collective, namely patient collectives. The purpose of this paper is to investigate if, and to what extent, patient collectives empower chronically ill patients. The results of the study show that some patient groups were able to contract collective agreements with health insurers, whereas others were not. The eligibility of a group's disease for compensation through the risk equalisation fund (which subsidises the costs for many but not all disorders) seems to determine whether or not a patient organisation is able to successfully negotiate a collective contract for its members. Another key factor for success is the presence of a large membership whose constituents have similar healthcare needs. If both of these factors are present, insurers are more likely to develop specific products for particular groups of patients, as is the case for people with diabetes. Furthermore, the presence of patient collectives accords patient associations with a new role. It may be possible for them to become powerful players in the health insurance market. However, this new role may also lead to tensions, both within and between associations

Bebb C, *et al.* Practice and patient characteristics related to blood pressure in patients with type 2 diabetes in primary care: a cross-sectional study. *Family Practice* 2007 Advance Access published online on October 25, 2007 DOI: 10.1093/fampra/cmm060

Background: Good blood pressure control reduces the risk of long-term complications of diabetes; however, most people with diabetes do not achieve recommended blood pressure targets. Objective: To quantify the relationships between patient and practice factors and blood pressure in patients with type 2 diabetes. Methods: A cross-sectional study was carried out in 42 general practices in Nottingham. Participants were 1534 people with type 2 diabetes. Patient characteristics were assessed by a clinical interview and case note review and practice characteristics by questionnaire. The outcome measures were systolic and diastolic blood pressure. Results: In all, 46% of participants had well-controlled blood pressure ($\leq 145/85$ mmHg) and 68% were on anti-hypertensive treatment. Systolic and diastolic blood pressure were significantly higher in males overall, in those with a body mass index ≥ 25 kg/m², and increased with alcohol consumption. Systolic blood pressure increased whereas diastolic blood pressure decreased with increasing age and duration of diabetes. Current smokers and ex-smokers had a significantly lower diastolic blood pressure than those who had never smoked. Patients from practices where blood pressure targets were negotiated with most patients had significantly lower mean systolic and diastolic blood pressure than those where targets were negotiated with few patients. Conclusions: A number of patient characteristics are associated with blood pressure. Negotiating individual goals for blood pressure may be important in achieving blood pressure control in patients with type 2 diabetes. Further research is required to confirm this finding and to explore the process of negotiating targets

Candib, LM. Obesity and diabetes in vulnerable populations: reflection on proximal and distal causes. *Annals of Family Medicine* 2007 5 (6) 547-56 DOI: 10.1370/afm.754

Around the world obesity and diabetes are climbing to epidemic proportion, even in countries previously characterized by scarcity. Likewise, people from low-income and minority communities, as well as immigrants from the developing world, increasingly visit physicians in North America with obesity, metabolic syndrome, or diabetes. Explanations limited to lifestyle factors such as diet and exercise are inadequate to explain the universality of what can be called a syndemic, a complex and widespread phenomenon in population health produced by multiple reinforcing conditions. Underlying the problem are complex factors-genetic, physiological, psychological, familial, social, economic, and political-coalescing to overdetermine these conditions. These interacting factors include events occurring during fetal life, maternal physiology and life context, the thrifty genotype, the nutritional transition, health impact of urbanization and immigration, social attributions and cultural perceptions of increased weight, and changes in food costs and availability resulting from globalization. Better appreciation of the complexity of causation underlying the worldwide epidemic of obesity and diabetes can refocus the work of clinicians and researchers to work at multiple levels to address prevention and treatment for these conditions among vulnerable populations

Chin MH, et al. Improving and sustaining diabetes care in community health centers with the health disparities collaboratives. *Medical Care* 2007 45 (12) 1135-43 DOI; 10.1097/MLR.0b013e31812da80e

Background In 1998, the Health Resources and Services Administration's Bureau of Primary Health Care began the Health Disparities Collaboratives (HDC) to improve chronic disease management in community health centers (HCs) nationwide. The HDC incorporates rapid quality improvement, a chronic care model, and best practice learning sessions. Objectives:: To determine whether the HDC improves diabetes care in HCs over 4 years and whether more intensive interventions enhance care further. Subjects:: Chart review of 2364, 2417, and 2212 randomly selected patients with diabetes from 34 HCs in 17 states in 1998, 2000, and 2002, respectively. Measures:: American Diabetes Association standards. Research design:: We performed a randomized controlled trial with an embedded prospective longitudinal study. We randomized 34 HCs that had undergone 1-2 years of the HDC. The standard-intensity arm continued the baseline HDC intervention. High-intensity arm centers received 4 additional learning sessions, provider training in behavioral change, and patient empowerment materials. To assess the impact of the HDC, we analyzed changes in clinical processes and outcomes in the standard-intensity centers. To determine the effect of more intensive interventions, we compared the standard- and high-intensity centers. Results:: Between 1998 and 2002, HCs undertaking the standard HDC improved 11 diabetes processes and lowered hemoglobin A1c [-0.45%; 95% confidence interval (CI), -0.72 to -0.17] and low-density lipoprotein cholesterol (-19.7 mg/dL; 95% CI, -25.8 to -13.6). High-intensity intervention centers had greater use of angiotensin converting enzyme inhibitors [adjusted odds ratio (OR), 1.47; 95% CI, 1.07-2.01] and aspirin (OR, 2.20; 95% CI, 1.28-3.76), but lower use of dietary

(OR, 0.24; 95% CI, 0.08-0.68) and exercise counseling (OR, 0.34; 95% CI, 0.15-0.75). Conclusions:: Diabetes care and outcomes improved in HCs during the first 4 years of the HDC quality improvement collaborative. More intensive interventions helped marginally

Escudero-Carretero MJ, et al Expectations held by type 1 and 2 diabetes mellitus patients and their relatives: the importance of facilitating the health-care process. *Health Expectations* 2007 10 (4) 337-49. DOI: 10.1111/j.1369-7625.2007.00452.x

Aim To understand the expectations held by type 1 and 2 diabetes mellitus (DM 1 & 2) patients and their relatives regarding the health-care provided to them. Design Qualitative. Focus groups. Setting and participants Andalusia. A theoretical sample that includes the most characteristic profiles. Thirty-one subjects with DM. Segmentation characteristics: receiving health-care for DM in Primary or Specialized care, living in urban and rural areas, men and women, age, varying diagnosis times, DM course and consequences. Subjects were recruited by health-care professionals at reference care centres. Results Patients expect their health-care professionals to be understanding, to treat them with kindness and respect, to have good communication skills, to provide information in a non-authoritarian manner while fully acknowledging patients' know-how. Regarding the health-care system, their expectations focus on the system's ability to respond when required to do so, through a relevant professional, along with readily available equipment for treatment. The expectations of people affected by DM1 focus on leading a normal life and not having their educational, labour, social and family opportunities limited by the disease. Expectations in people with DM2 tend towards avoiding what they know has happened to other patients. Conclusions 'Facilitating', is a key word. Both the health-care system and its professionals must pay keener attention to the emotional aspects of the disease and its process, adopting a comprehensive approach to care. It is vital that health-care professionals take an active interest in the course of their patient's disease, promoting accessibility and an atmosphere of trust and flexibility

Entwistle V, et al. Involvement in treatment decision-making: Its meaning to people with diabetes and implications for conceptualisation. *Social Science and Medicine* 2007. Epub ahead of print DOI; 10.1016/j.socscimed.2007.09.001

Patient involvement in decision-making is widely regarded as an important feature of good-quality healthcare. Policy-makers have been particularly concerned to ensure that patients are informed about and enabled to choose between relevant treatment options, but it is not clear how patients understand and value involvement. We investigated the meaning of involvement in treatment decision-making for people with diabetes. We conducted semi-structured interviews with 18 people aged between 20 and 79 who had type 1 or type 2 diabetes selected from 4 multi-practitioner outpatient clinics in the Grampian area of Scotland. We used several strategies to probe their understandings of involvement, including a discussion of how they would respond to a question about involvement in treatment decisions that appears on the National Patient Survey used to monitor the quality of healthcare in England. Participants associated involvement in decision-making with a number of features relating to the ethos and feel of healthcare encounters (welcoming; respectful; facilitative of patients' contributions; and non-

judgemental); communication about health problems (practitioners attending to patients' views and patients feeling listened to; practitioners giving clear explanations based on their professional knowledge and patients understanding these); and communication about treatments (practitioners explaining treatment rationales in ways that patients understand and enabling patients to feel they have a say). Our findings have implications for practical attempts to involve patients in decisions about their care and for the conceptualisation and assessment of patient involvement. They suggest that practitioners who aspire to facilitate patient involvement should attend to the ethos they foster in consultations and the way they discuss problems as well as to the provision of information about treatment options and the scope patients have to influence decisions. Models and taxonomies of patient involvement in decision-making need to be developed to accommodate both problem-solving phases and the relational and subjective dimensions of involvement.

Fitzgerald JT, et al Patient and provider perceptions of diabetes: measuring and evaluating differences. *Patient Education and Counseling* Epub ahead of print 2007. DOI: 10.1016/j.pec.2007.09.005

Objective This study measures diabetes care perceptions of patients and their providers, and examines perceptions differences of patient-provider pairs. **Methods** Patient and provider perceptions were assessed using the Diabetes Semantic Differential Scales (DSDS) which ask respondents to rate diabetes care concepts using contrasting adjective pairs. The DSDS was scored by two methods: using means and using factor analysis. Persons with diabetes 40-years-old or older were recruited. Using a "snowball" sampling strategy, potential provider participants were identified by their patients; 71 providers agreed. These providers represented 51% of the patient participants and created 138 patient-provider pairs. **Results** For the mean scores, there were significant differences between patients and providers for 5 of the 18 semantic differentials (28%). Similarly, the factor scores indicated significant differences for 14 of 54 factors (26%). The effect sizes indicated practical differences. **Conclusion** Significant differences exist between patient and provider perceptions. Generally, patients have the more positive diabetes perceptions. **Practice implications** During patient and provider discussions, participants can perceive diabetes concepts differently. The DSDS can determine perception differences. While it is best to use factor analyses to score the DSDS, mean scores are more easily calculated and indicate the broad conceptual areas where patient and provider differ.

Hamann J et al Participation preferences of patients with acute and chronic conditions. *Health Expectations* . 2007 10 (4) 358-63. DOI: 10.1111/j.1369-7625.2007.00458.x

Background There is little knowledge as to whether the chronicity of a disease affects patients' desire for participation. **Aim** To study whether participation preferences vary according to the type of disease. **Design, participants and methods** Data of 1393 patients from six trials with different medical conditions (hypertension, depression, breast cancer, schizophrenia, multiple sclerosis, minor traumas) were pooled and analysed, using multiple regression analysis controlling for socio-demographic variables. **Results**

Younger age, better education as well as female gender accounted for a small but statistically significantly greater desire to participate. Patients suffering from multiple sclerosis (MS) exhibited significantly higher participation preferences than the other diagnostic groups. There were no major differences between the other diagnostic groups. Age, gender, education and diagnosis explained only 14% of the variance. Conclusions We found no clear differences between chronic and acute conditions. However, patients suffering from MS, a chronic condition, were clearly different from all other diagnostic groups. The reasons for this difference remain unclear. The predictive value of socio-demography and type of illness is low

Kennedy A, Rogers A, Bower P. Support for self care for patients with chronic disease. *British Medical Journal* 2007 335 (7627) 968-70 DOI: 10.1136/bmj.39372.540903.94

Effectively managing long term conditions and the burden they place on patients, professionals, and services is a major focus of current health policy. Support for self care is increasingly viewed as a core component of the management of long term conditions. However, despite the enthusiastic promotion of self care, randomised controlled trials often show modest benefits. We examine why current initiatives fail to deliver and suggest what needs to be done.

Lucas A et al The validity of diagnostic support of an asthma/COPD service in primary care. *British Journal of General Practice* 2007 57 (544) 892-6. DOI: 10.3399/096016407782317883

Background: To support GPs in diagnosing and monitoring their patients with asthma/chronic obstructive pulmonary disease (COPD), 'asthma/COPD services' have been developed. Within these services, pulmonologists perform structured diagnostic and therapeutic assessments based on the combination of written history data and spirometry. AIM: This study determines the validity of the diagnosis and advice when assessed using only written information. Design of study: The results of the diagnostic procedures of an asthma/COPD service were compared with the results of regular office consultations by pulmonologists. Setting: From January until August 2004, two pulmonologists examined 80 randomly selected patients referred to an asthma/COPD service in Eindhoven, the Netherlands. Method: Concordance was analysed between diagnosis and advice based on written spirometry and history data, with assessments based on live consultations with the same patients by pulmonologists. Results: The validity of the assessed diagnosis was high (Cohen's kappa = 0.82). When the diagnosis was uncertain, the advice for medical treatment scored low in validity (Cohen's kappa = 0.39). The advice for additional diagnostic examinations had a high internal validity: in half of the patients, uncertainty in diagnosis turned into a definite diagnosis of asthma/COPD, or another cause for the complaints of the patient was revealed; in the other half, the diagnosis of asthma/COPD could be rejected. Conclusions: A structured asthma/COPD service offering diagnosis and diagnostic advice assessed from written spirometry and history data is a new and valid facility that can support the GP who faces the complicated diagnostic procedures in a progressive number of patients with asthma/COPD

Parchman ML, et al Risk of Coronary Artery Disease in Type 2 Diabetes and the Delivery of Care Consistent With the Chronic Care Model in Primary Care Settings: a STARNet Study. *Medical Care* 2007 45 (12) 1129-34. DOI: 10.1097/MLR.0b013e318148431e

Background:: Modifiable risks for coronary heart disease (CHD) in type 2 diabetes include glucose, blood pressure, lipid control, and smoking. The chronic care model (CCM) provides an organizational framework for improving these outcomes. Objective:: To examine the relationship between CHD risk attributable to modifiable risk factors among patients with type 2 diabetes and whether care delivered in primary care settings is consistent with the CCM. Subjects/Methods:: Approximately 30 patients in each of 20 primary care clinics. CHD risk factors were assessed by patient survey and chart abstraction. Absolute 10-year CHD risk was calculated using the UK Prospective Diabetes Study risk engine. Attributable risk was calculated by setting all 4 modifiable risk factors to guideline indicated values, recalculating the risk, and subtracting it from the absolute risk. In each clinic, the consistency of care with the CCM was evaluated using the Assessment of Chronic Illness Care (ACIC) survey. Results:: Only 15.4% had guideline-recommended control of A1c, blood pressure, and lipids. The absolute 10-year risk CHD was 16.2% (SD 16.6). One-third of this risk, 5.0% (SD 7.4), was attributable to poor risk factor control. After controlling for patient and clinic characteristics, the ACIC score was inversely associated with attributable risk: a 1 point increase in the ACIC score was associated with a 16% (95% CI, 5-26%) relative decrease in attributable risk. Discussion:: The degree to which care delivered in a primary care clinic conforms to the CCM is an important predictor of the 10-year risk of CHD among patients with type 2 diabetes

Rafanelli C, Fava GA, Sonino N. Sequential treatment of depression in primary care. *International Journal of Clinical Practice* 2007 61 (10) 1719-29 DOI: 10.1111/j.1742-1241.2007.01342.x

In the past decade, in clinical psychiatry several investigations suggested the usefulness of a sequential way of integrating pharmacotherapy and psychotherapy in mood disorders. The aim of this paper was to illustrate the practical implications of sequential treatment strategy for depression in primary care, with particular reference to the increasingly common problem of recurrent depression. Methods: The Authors tried to integrate the evidence which derives from meta-analyses and comprehensive general reviews with the insights which derive from controlled studies concerned with specific populations. Conclusions: The sequential treatment of mood disorders is an intensive, two-stage approach, which derives from the awareness that one course of treatment with a specific tool (whether pharmacotherapy or psychotherapy) is unlikely to entail solution to the affective disturbances of patients, both in research and in clinical practice settings. The aim of the sequential approach is to add therapeutic ingredients as long as they are needed. In this sense, it introduces a conceptual shift in clinical practice.

Sarkar U, et al. Preferences for self-management support: Findings from a survey of diabetes patients in safety-net health systems. *Patient Education and Counseling* 2007 Epub ahead of publication 7/11/2007 DOI: 10.1016/j.pec.2007.09.008

Objective We sought to identify interest in different modes of self-management support among diabetes patients cared for in public hospitals, and to assess whether demographic or disease-specific factors were associated with patient preferences. We explored the possible role of a perceived communication need in influencing interest in self-management support. **Methods** Telephone survey of a random sample of 796 English and Spanish-speaking diabetes patients (response rate 47%) recruited from four urban US public hospital systems. In multivariate models, we measured the association of race/ethnicity, primary language, self-reported health literacy, self-efficacy, and diabetes-related factors on patients' interest in three self-management support strategies (telephone support, group medical visits, and Internet-based support). We explored the extent to which patients believed that better communication with providers would improve their diabetes control, and whether this perception altered the relationship between patient factors and self-management support acceptance. **Results** Sixty-nine percent of respondents reported interest in telephone support, 55% in group medical visits, and 42% in Internet. Compared to Non-Hispanic Whites, Spanish-speaking Hispanics were more interested in telephone support (OR 3.45, 95% CI 1.97-6.05) and group medical visits (OR 2.45, 95% CI 1.49-4.02), but less interested in Internet self-management support (OR 0.56, 95% CI 0.33-0.93). African-Americans were more interested than Whites in all three self-management support strategies. Patients with limited self-reported health literacy were more likely to be interested in telephone support than those not reporting literacy deficits. Forty percent reported that their diabetes would be better controlled if they communicated better with their health care provider. This perceived communication benefit was independently associated with interest in self-management support ($p < 0.001$), but its inclusion in models did not alter the strengths of the main associations between patient characteristics and self-management support preferences. **Conclusion** Many diabetes patients in safety-net settings report an interest in receiving self-management support, but preferences for modes of delivery of self-management support vary by race/ethnicity, language proficiency, and self-reported health literacy. **Practice implications** Public health systems should consider offering a range of self-management support services to meet the needs of their diverse patient populations. More broad dissemination and implementation of self-management support may help address the unmet need for better provider communication among diabetes patients in these settings.

EVIDENCE BASED MEDICINE

Carlsen B, Glenton C, Pope C. Thou shalt versus thou shalt not: a meta-synthesis of GPs' attitudes to clinical practice guidelines *British Journal of General Practice* 2007 57 (545) 971-8. DOI: 10.3399/096016407782604820

Background: GPs' adherence to clinical practice guidelines is variable. Barriers to guideline implementation have been identified but qualitative studies have not been synthesised to explore what underpins these attitudes. Aim: To explore and synthesise qualitative research on GPs' attitudes to and experiences with clinical practice guidelines. Design of study: Systematic review and meta-synthesis of qualitative studies. Method: PubMed, CINAHL, EMBASE, Social Science Citation Index, and Science Citation Index were used as data sources, and independent data extraction was carried out. Discrepancies were resolved by consensus. Initial thematic analysis was conducted, followed by interpretative synthesis. Results. Seventeen studies met the inclusion criteria. Five were excluded following quality appraisal. Twelve papers were synthesised which reported research in the UK, US, Canada, and the Netherlands, and covered different clinical guideline topics. Six themes were identified: questioning the guidelines, GPs' experience, preserving the doctor-patient relationship, professional responsibility, practical issues, and guideline format. Comparative analysis and synthesis revealed that GPs' reasons for not following guidelines differed according to whether the guideline in question was prescriptive, in that it encouraged a certain type of behaviour or treatment, or proscriptive, in that it discouraged certain treatments or behaviours. Conclusion: Previous analyses of guidelines have focused on professional attitudes and organisational barriers to adherence. This synthesis suggests that the purpose of the guideline, whether its aims are prescriptive or proscriptive, may influence if and how guidelines are received and implemented.

Heneghan C, et al. Hypertension guideline recommendations in general practice: awareness, agreement, adoption, and adherence. *British Journal of General Practice* 2007;57 (545) 948-52. DOI: 10.3399/096016407782604965

Background: GPs vary greatly in their clinical management of hypertension, for reasons that are poorly understood. Aim: To explore GPs' awareness of current hypertension guidelines and their self-reported implementation of them in clinical practice. Design of study: Questionnaire survey via the internet. Setting: Primary care. Method: Survey of GPs ($n = 401$), based on the 'awareness-to-adherence' model of behavioural change. Results: While awareness of recommendations was high, agreement and adoption were often less so. Almost all practitioners (99%) were aware of the guidance on statin therapy but fewer than half (43%; 95% confidence interval [CI] 38-48%) adhered to the recommendation in practice. Three-quarters (77%) were aware that blood pressure should initially be measured in both arms, but only 30% agreed with the recommendation (95% CI = 26 to 34%), and 13% (95% CI = 10 to 16%) adhered to it. Although the adoption of a recommendation was usually consequent on agreement with it, 19% of GPs (95% CI = 15 to 23%) reported adherence to financially incentivised guidance on statin therapy without either being aware of it or in agreement with it. No significant association was found among age, sex, year of graduation, or post held and level of awareness, agreement, or adoption. Conclusion: The specific barrier and action needed to promote application of hypertension guidelines varies with each clinical action. Lack of awareness is seldom the problem. Most GPs are unlikely to implement elements of guidance they disagree with even if given financial incentives. High adherence requires a reflective workforce that can respond to the scientific evidence underpinning the guidance.

HEALTH ECONOMICS

Bate A, Donaldson C, Murtagh MJ. Managing to manage healthcare resources in the English NHS? What can health economics teach? What can health economics learn? *Health Policy* 2007; 84 :249-61. DOI; 10.1016/j.healthpol.2007.04.001

Objectives To provide a 'thick description' of how decision-makers understand and manage healthcare prioritisation decisions, and to explore the potential for using economic frameworks in the context of the NHS in England. **Methods** : Interviews were conducted with 22 key decision-makers from six Primary Care Trusts (PCTs) in northern England. A constant comparative approach was used to identify broad themes and sub-themes. **Results** : Six broad themes emerged from the analysis. In summary, decision-makers recognised the concepts of resources scarcity, competing claims, and the need for choices and trade-offs to be made. Decision-makers even went on to identify a common set of principles that ought to guide commissioning decisions. However, the process of commissioning was dominated by political, historical and clinical methods of commissioning which, failed to recognise these concepts in practice, and departed from the principles. As a result, the commissioning process was viewed as not being systematic or transparent and, therefore, seen as underperforming. **Conclusions** : Health economists need to acknowledge the importance of contextual factors and the realities of priority setting. Our research suggests that the emphasis should be on integrating principles of economics into a management process rather than expecting decision-makers to apply the output of ever more seemingly 'technically sound' health economic methods which cannot reflect the dominating and driving complexities of the commissioning process.

Castelli A, et al. Improving the measurement of health system output growth. *Health Economics* 2007 16 (10) 1091-107. DOI; 10.1002/hec.1211

National income accounting practice is to weight health service activities by their cost so that they can be aggregated into an output index. Quality changes are ignored. We propose an 'ideal' value weighted output index in which the value attached to each output reflects its contribution to health outcomes and other characteristics valued by patients. Calculation of the index for the health system as a whole is currently infeasible because of a lack of data, especially on health outcomes. We demonstrate alternative ways of combining health outcome data with existing information on post-treatment survival, life expectancy and waiting times to construct quality adjusted cost weighted and health outcome weighted indices for a small set of hospital activities for which there are health outcome data.

**Levaggi R, Rochaix L. Exit, choice or loyalty: patient driven competition in primary care. *Annals of Public and Cooperative Economics* 2007 78 501-35
DOI:**

Abstract: This paper analyses the potential costs and benefits from patient driven competition between GPs and specialists by comparing gate-keeping with direct access to

specialist care. The two access rules are compared under fee-for-service and capitation, on their performance at minimizing both total financial costs and patients' opportunity cost of time in care. To analyse the social cost of patients' potential access mistakes, two types of illnesses are considered, with two levels of severity and an equal probability for each of the four events. The results generated under information symmetry show that gate-keeping always dominates in terms of minimizing financial cost. Results are extended to show that under patients' heterogeneity with respect to time preferences, allocative efficiency can be enhanced in gate-keeping by giving the patient the option to seek a specialist directly, provided he bears the extra cost. When turning to information asymmetry, results are reversed, and direct access is shown to be more cost effective. This is due to patients' ability to constrain providers' opportunistic behaviour by 'voting with their feet'. Beyond increasing allocative efficiency, patient choice is therefore found, under certain conditions, to contribute towards enhancing productive efficiency. Finally, introducing co-payments to share the financial risk associated with direct access potentially weakens patients' ability to curb providers' strategic behaviour. Under information asymmetry, direct access to specialist care should therefore remain free if patient's disutility in time in care is linear. When it is instead increasing, we show that a co-payment becomes necessary to curb specialists' information rent. Finally, under information asymmetry, the mixed solution (gate-keeping with optional direct access) improves on pure gate-keeping but is still suboptimal.

Rosenthal MB, et al Climbing up the pay-for-performance learning curve: where are the early adopters now? *Health Affairs (Millwood.)* 2007 26 1674-82 DOI: 10.1377/hlthaff.26.6.1674

The diffusion of performance-based payment incentives is arguably the most striking change in the U.S. health care system since the managed care era. Because there is little knowledge about best practices, sponsors of payment-incentive programs must learn by doing. We examine the experiences of twenty-seven early adopters and profile the evolution of their pay-for-performance (P4P) strategies as well as perceptions of key lessons learned. Our findings suggest that leading-edge sponsors of P4P have expanded the reach of their efforts, particularly with regard to specialists, and increasingly are focused on outcome and cost-efficiency measures, rather than clinical process measures alone

HEALTH INEQUALITIES

Bernard P, et al. Health inequalities and place: A theoretical conception of neighbourhood. *Social Science and Medicine* 2007;65 (9) 1835-52. DOI: 10.1016/j.socscimed.2007.05.037

In the past 10 years, interest in studying the relationship between area of residence and health has grown. During this period empirical relations between place and health have been observed at a variety of spatial scales, from census tracts to administrative units in

metropolitan areas to whole regions, and for a variety of health outcomes. Despite the richness of the data, there are relatively few publications offering theoretical explanations for these observations, and a sound conception of place itself is still lacking. Using place as a relational space linked to where people live, work and play, this paper conceptualises the nature of neighbourhoods as they contribute to the local production of health inequalities in everyday life. In reference to Giddens' structuration theory, we propose that neighbourhoods essentially involve the availability of, and access to, health-relevant resources in a geographically defined area. Taking inspiration from the work of Godbout on informal reciprocity, we further propose that such availability and access are regulated according to four different sets of rules: proximity, prices, rights, and informal reciprocity. Our theoretical framework suggests that these rules give rise to five domains, the physical, economic, institutional, local sociability, and community organisation domains which cut across neighbourhood environments through which residents may acquire resources that shape their lifecourse trajectory in health and social functioning.

Cox M, et al. Locality deprivation and Type 2 diabetes incidence: A local test of relative inequalities. *Social Science and Medicine* 2007 65 (9) 1953-64 DOI: 10.1016/j.socscimed.2007.05.043

There is increasing evidence that the socio-spatial context of the local area in which one lives can have an effect on health, but teasing out contextual influences is not a simple task. We examine whether the incidence of Type 2 diabetes in small areas in Tayside, Scotland is associated with deprivation in neighbouring areas, controlling for the deprivation of the area itself. As such, this is a genuinely 'contextual' variable situating each small area in the context of surrounding places. We test two opposing hypotheses. First, a 'psycho-social' hypothesis might suggest that negative social comparisons made by individuals in relation to those who surround them could lead to chronic low-level stress via psycho-social pathways, the physiological effects of which could promote diabetes. Thus, we would expect people living in deprived areas surrounded by less deprived areas to have an increased risk of diabetes, compared to those living in similarly deprived areas that are surrounded by equally or more deprived areas. Alternatively, a neo-materialist approach might suggest that the social, cultural and environmental resources in the surrounding environment will influence circumstances in a particular area of interest. Poorer areas surrounded by less deprived areas would benefit from the better resources in the wider locality, while less deprived areas surrounded by poorer areas may be hampered by the poorer resources available nearby. We refer to this as the 'pull-up/pull-down' hypothesis. Our results show that, as expected, area deprivation is positively related to diabetes incidence ($p < 0.001$), whilst deprivation inequality between areas and their neighbours is negatively related ($p = 0.006$). Type 2 diabetes is more common in deprived areas, but lower in deprived areas that are surrounded by relatively less deprived areas. On the other hand, less deprived areas that are surrounded by relatively more deprived areas have higher diabetes incidence than would be expected from the deprivation of the area alone. Our model results are consistent with a pull-up/pull-down model and lend no support to a 'psycho-social' interpretation at this local scale of analysis.

Kai J, et al Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study. *PLoS.Med.* 2007 4:e323. DOI: 10.1371/journal.pmed.0040323

Background: While ethnic disparities in health and health care are increasing, evidence on how to enhance quality of care and reduce inequalities remains limited. Despite growth in the scope and application of guidelines on "cultural competence," remarkably little is known about how practising health professionals experience and perceive their work with patients from diverse ethnic communities. Using cancer care as a clinical context, we aimed to explore this with a range of health professionals to inform interventions to enhance quality of care. Methods and findings: We conducted a qualitative study involving 18 focus groups with a purposeful sample of 106 health professionals of differing disciplines, in primary and secondary care settings, working with patient populations of varying ethnic diversity in the Midlands of the UK. Data were analysed by constant comparison and we undertook processes for validation of analysis. We found that, as they sought to offer appropriate care, health professionals wrestled with considerable uncertainty and apprehension in responding to the needs of patients of ethnicities different from their own. They emphasised their perceived ignorance about cultural difference and were anxious about being culturally inappropriate, causing affront, or appearing discriminatory or racist. Professionals' ability to think and act flexibly or creatively faltered. Although trying to do their best, professionals' uncertainty was disempowering, creating a disabling hesitancy and inertia in their practice. Most professionals sought and applied a knowledge-based cultural expertise approach to patients, though some identified the risk of engendering stereotypical expectations of patients. Professionals' uncertainty and disempowerment had the potential to perpetuate each other, to the detriment of patient care. Conclusions: This study suggests potential mechanisms by which health professionals may inadvertently contribute to ethnic disparities in health care. It identifies critical opportunities to empower health professionals to respond more effectively. Interventions should help professionals acknowledge their uncertainty and its potential to create inertia in their practice. A shift away from a cultural expertise model toward a greater focus on each patient as an individual may help

Mercer SW, Watt GC. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. *Annals of Family Medicine* 2007 5 (6) 503-10. DOI: 10.1370/afm.778

Purpose: The inverse care law states that the availability of good medical care tends to vary inversely with the need for it in the population served, but there is little research on how the inverse care law actually operates. Methods: A questionnaire study was carried out on 3,044 National Health Service (NHS) patients attending 26 general practitioners (GPs); 16 in poor areas (most deprived) and 10 in affluent areas (least deprived) in the west of Scotland. Data were collected on demographic and socioeconomic factors, health variables, and a range of factors relating to quality of care. Results: Compared with patients in least deprived areas, patients in the most deprived areas had a greater number of psychological problems, more long-term illness, more multimorbidity, and more chronic health problems. Access to care generally took longer, and satisfaction with

access was significantly lower in the most deprived areas. Patients in the most deprived areas had more problems to discuss (especially psychosocial), yet clinical encounter length was generally shorter. GP stress was higher and patient enablement was lower in encounters dealing with psychosocial problems in the most deprived areas. Variation in patient enablement between GPs was related to both GP empathy and severity of deprivation. Conclusions: The increased burden of ill health and multimorbidity in poor communities results in high demands on clinical encounters in primary care. Poorer access, less time, higher GP stress, and lower patient enablement are some of the ways that the inverse care law continues to operate within the NHS and confounds attempts to narrow health inequalities

Popay J, et al Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part I: the GP perspective. *Journal of Epidemiology and Community Health* 2007 61 (11) 966-71. DOI: 10.1136/jech.2007.061937

Objectives: This study aimed to describe social problems presented to general practitioners (GPs) in UK inner cities and GPs' responses; describe patients' help-seeking pathways; and consider how these pathways can be improved. Methods: The study involved a pilot survey and follow-up qualitative interviews with patients in two inner city areas in London and Salford in 2001-2. The pilot survey involved five practices in each locality. GPs completed questionnaires on 57 people presenting with social problems. A diversity sample of 12 patients were followed up for interview. Results: Study results are presented in two parts. This paper focuses on the GP survey results. People were presenting with a wide range of social problems, and multiple problems were also common. Problems with welfare benefits and housing were the most common, but GPs were most likely to refer to counselling services and to a lesser extent to generic advice services. Some GPs would have preferred to refer patients to more problem-specific services but did not believe these were available. Conclusions: The study highlights the role GPs play in helping people deal with social problems but also identifies limitations in their response to these problems. It points to the need for more integrated pathways to help and advice for social problems. Primary care can make existing pathways more visible and accessible, and create new pathways through, for example, the new commissioning role and extending the scope of social prescribing

Popay J, et al Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part II: lay perspectives. *Journal of Epidemiology and Community Health* 2007 61 (11) 972-7 DOI: 10.1136/jech.2007.061945

Objectives: This study aimed to describe social problems presented to general practitioners (GPs) in UK inner cities and GPs' responses; describe patients help-seeking pathways; and consider how these pathways can be improved. Methods: The study involved a pilot survey and follow-up qualitative interviews with patients in two inner city areas in London and Salford in 2001-2. The pilot survey involved five practices in each locality. GPs completed questionnaires on 57 people presenting with social problems. A diversity sample of 12 patients was followed up for interview. Results:

Study results are presented in two parts. Here (Part II) qualitative research results are reported highlighting four themes: the complex and enduring nature of social problems; the persistence people display seeking help; the fragmented and problematic pathways available; and the roles GPs play as: primary medical adviser; formal gateway to another service; advocates or facilitators to another service; and sources of support and advice during a process of recovery. Commonly, GPs occupied more than one role. Conclusions: GPs do help people deal with social problems, but their responses are limited. More integrated pathways to help and advice for social problems are needed. Existing pathways could be more visible and accessible, and new pathways developed through commissioning and extending social prescribing. More partnerships across sectors may create more co-ordinated provision, but these are notoriously difficult, and other trends such as the focus on lifestyle issues and long-standing conditions may make it more difficult for people with social needs to access support

Scambler G. Social structure and the production, reproduction and durability of health inequalities. *Social Theory and Health* 2007 5 (4) 297-315 DOI: 10.1057/palgrave.sth.8700101

This paper is based on the premise that the concept of social structure so familiar during the heyday of classical sociology has been neglected in the contemporary sociological study of health inequalities. After a brief preliminary discourse on the structuring of agency, a number of published models are introduced and some of their key limitations debated. The framework for a more sociologically progressive research programme is then ventured, building on the author's critical realist and critical theoretical approach to the changing dynamic of class relations of the economy and command relations of the state and to the changeable distribution of asset flows. The concepts of 'alienation', 'surveillance' and 'aspirational consumerism' are used.

Starfield B, Birn A E. Income redistribution is not enough: income inequality, social welfare programs, and achieving equity in health. *Journal of Epidemiology and Community Health* 2007 61 (12) 1038-41. DOI: 10.1136/jech.2006.054627

Income inequality is widely assumed to be a major contributor to poorer health at national and subnational levels. According to this assumption, the most appropriate policy strategy to improve equity in health is income redistribution. This paper considers reasons why tackling income inequality alone could be an inadequate approach to reducing differences in health across social classes and other population subgroups, and makes the case that universal social programs are critical to reducing inequities in health. A health system oriented around a strong primary care base is an example of such a strategy.

Wilkinson RG, Pickett KE. The problems of relative deprivation: Why some societies do better than others. *Social Science and Medicine* 2007 65 (9) 1965-78. DOI: doi:10.1016/j.socscimed.2007.05.041

In this paper, we present evidence which suggests that key processes of social status differentiation, affecting health and numerous other social outcomes, take place at the societal level. Understanding them seems likely to involve analyses and comparisons of

whole societies. Using income inequality as an indicator and determinant of the scale of socioeconomic stratification in a society, we show that many problems associated with relative deprivation are more prevalent in more unequal societies. We summarise previously published evidence suggesting that this may be true of morbidity and mortality, obesity, teenage birth rates, mental illness, homicide, low trust, low social capital, hostility, and racism. To these we add new analyses which suggest that this is also true of poor educational performance among school children, the proportion of the population imprisoned, drug overdose mortality and low social mobility. That ill health and a wide range of other social problems associated with social status within societies are also more common in more unequal societies, may imply that income inequality is central to the creation of the apparently deep-seated social problems associated with poverty, relative deprivation or low social status. We suggest that the degree of material inequality in a society may not only be central to the social forces involved in national patterns of social stratification, but also that many of the problems related to low social status may be amenable to changes in income distribution. If the prevalence of these problems varies so much from society to society according to differences in income distribution, it suggests that the familiar social gradients in health and other outcomes are unlikely to result from social mobility sorting people merely by prior characteristics. Instead, the picture suggests that their frequency in a population is affected by the scale of social stratification that differs substantially from one society to another

Williams N H, et al. Effectiveness of exercise-referral schemes to promote physical activity in adults: systematic review. *British Journal of General Practice* 2007 57 (545) 979-86. DOI: 10.3399/096016407782604866

Background: Despite the health benefits of physical activity, most adults do not take the recommended amount of exercise. Aim: To assess whether exercise-referral schemes are effective in improving exercise participation in sedentary adults. Design of study: Systematic review. Method: Studies were identified by searching MEDLINE, CINAHL, EMBASE, AMED, PsycINFO, SPORTDiscus, The Cochrane Library and SIGLE until March 2007. Randomised controlled trials (RCTs), observational studies, process evaluations and qualitative studies of exercise-referral schemes, defined as referral by a primary care clinician to a programme that encouraged physical activity or exercise were included. RCT results were combined in a meta-analysis where there was sufficient homogeneity. Results: Eighteen studies were included in the review. These comprised six RCTs, one non-randomised controlled study, four observational studies, six process evaluations and one qualitative study. In addition, two of the RCTs and two of the process evaluations incorporated a qualitative component. Results from five RCTs were combined in a meta-analysis. There was a statistically significant increase in the numbers of participants doing moderate exercise with a combined relative risk of 1.20 (95% confidence intervals = 1.06 to 1.35). This means that 17 sedentary adults would need to be referred for one to become moderately active. This small effect may be at least partly due to poor rates of uptake and adherence to the exercise schemes. Conclusion: Exercise-referral schemes have a small effect on increasing physical activity in sedentary people. The key challenge, if future exercise-referral schemes are to be commissioned by the NHS, is to increase uptake and improve adherence by addressing the barriers described in these studies.

INFORMATION AND COMMUNICATION TECHNOLOGY IN HEALTH CARE

Checkland K, McDonald R, Harrison S Ticking boxes and changing the social world: data collection and the new UK general practice contract Social Policy and Administration 2007 41 (7) 693-710 DOI: 10.1111/j.1467-9515.2007.00580.x

The new General Medical Services contract was introduced into general practice in the UK in 2004, and it links pay to performance far more than in the past. As a result, accurate data collection about patients and the care that they receive is now not only important for good patient care but also to prove that targets are being met. The use of electronic records and information technology has thus become much more sophisticated. This article reports the results from an ethnographic study of the early stages of the new contract in two general practices. As expected, electronic data collection had increased in importance in both practices, with consequences both for clinician-patient interactions and for the structures and processes in the practices, as uniform data collection instruments are put in place that privilege 'hard' biomedical data that can be easily coded above 'softer', more patient-centred information. Roles and responsibilities had been changed to reflect the needs of the new systems, and new software applications allowed increased surveillance of both doctors' and nurses' performance; both of these had an impact on patterns of authority in our study practices. Furthermore, the structural changes that were found acted to embed the new ways of working, ensuring their reproduction in the future. In spite of these effects, we found little opposition to or critical reflection on the changes, and the doctors in our study continued to view their improved computer systems as neutral recording devices. The implication of these findings is discussed.

Finch T L, et al. Future patients? Telehealthcare, roles and responsibilities. *Health and Social Care in the Community* Online Early article 2007. DOI: 10.1111/j.1365-2524.2007.00726.x

Increasing use of information and communication technologies is said to be transforming health care. Telehealthcare enables medical consultations to be conducted between patients and health professionals across different locations. Such technologies imply new relationships between patients and health professionals. This study aimed to understand how policy and practice in relation to telehealthcare suggests new conceptualisations of 'the patient'. In-depth semistructured interviews ($n = 38$) were conducted with key informants from across the UK, known to have involvement or interest in telehealthcare from a variety of perspectives: health professionals ($n = 11$), patient advocates ($n = 7$), telemedicine experts ($n = 6$), policy-makers ($n = 4$), administrators ($n = 4$), researchers ($n = 3$) and technologists ($n = 3$). Interviews were conducted either in person or over the telephone, and were audio-recorded. Data were analysed thematically with ongoing cross-validation of data interpretation between members of the research team. The results indicated divergent views about the role of the patient, although accounts of patients becoming 'educated self-managers', taking on a more active role in their healthcare, were predominant. Beliefs about the impact of telehealthcare on patients were focused on

perceived 'priorities' such as access, location of services, confidentiality and choice; however, there remains little understanding of the trade-offs that patients are willing to make in the context of technologically mediated health care. The results also highlight ideas around how patients relate to technologies; the extent to which technologies might fragment care and medicine in new or unexpected ways, and participation and absence of patients in decision-making about policies and services. The results of this study have important implications for the ways in which relationships between health professionals and patients are managed in practice, and raise important questions for public participation in service development.

Randell R, et al Effects of computerized decision support systems on nursing performance and patient outcomes: a systematic review. *Journal of Health Services Research and Policy* 2007 12: (4) 242-51. DOI: 10.1258/135581907782101543

Objective: To examine the effect of computerized decision support systems (CDSSs) on nursing performance and patient outcomes. Method: Fifteen databases, including Medline and CINAHL, were searched up to May 2006 together with reference lists of included studies and relevant reviews. Randomized controlled trials, controlled clinical trials, controlled before and after studies and interrupted time series studies that assessed the effects of CDSS use by nurses in a clinical setting on measurable professional and/or patient outcomes were included. Results: Eight studies, three comparing nurses using CDSS with nurses not using CDSS and five comparing nurses using CDSS with other health professionals not using CDSS, were included. Risk of contamination was a concern in four studies. The effect of CDSS on nursing performance and patient outcomes was inconsistent. Conclusion: The introduction of CDSS may not necessarily lead to a positive outcome; further studies are needed in order to identify contexts in which CDSS use by nurses is most effective. CDSS are complex interventions and should be evaluated as such; future studies should explore the impact of the users and the protocol on which the CDSS is based, reporting details of both. Contamination is a significant issue when evaluating CDSS, so it is important that randomization is at the practitioner or the unit level. Future systematic reviews should focus on particular uses of CDSS

MEDICINES MANAGEMENT

Campion P, Hilton A, Irving G. Shared prescribing? A focus group study with community pharmacists. *Primary Health Care Research and Development* 2007 8 (4) 308-14. DOI; 10.1017/S1463423607000400

The RESPECT (Randomised Evaluation of Shared Prescribing for the Elderly in the Community, randomised over Time) trial was a multi-centre pragmatic trial of pharmaceutical care in the community, which took place in five areas of East and North Yorkshire. This paper reports a qualitative study designed to explore attitudes of community pharmacists towards the process of 'pharmaceutical care' as tested in the trial. We recruited 21 pharmacists from the trial into four focus groups, moderated by an

independent researcher, and analysed using a thematic qualitative approach. Four themes emerged from the data: the pharmacist–patient relationship; the pharmacist–general practitioner (GP) relationship; the pharmacists' continuing professional development; and the role of peer support. Pharmacists welcomed this opportunity for more collaborative working with patients, GPs and peers. There is evidence of sub-optimal teamwork between community pharmacists and GP prescribers, which could be improved by more joint training and by new extended roles for pharmacists.

Rashidian A, Eccles MP, Russell I. Falling on stony ground? A qualitative study of implementation of clinical guidelines' prescribing recommendations in primary care. *Health Policy* 2007. Epub ahead of publication DOI: 10.1016/j.healthpol.2007.07.011

Objectives We aimed to explore key themes for the implementation of guidelines' prescribing recommendations. **Methods** We interviewed a purposeful sample of 25 participants in British primary care in late 2000 and early 2001. Thirteen were academics in primary care and 12 were non-academic GPs. We asked about implementation of guidelines for five conditions (asthma, coronary heart disease prevention, depression, epilepsy, menorrhagia) ensuring variation in complexity, role of prescribing in patient management, GP role in prescribing and GP awareness of guidelines. We used the Theory of Planned Behaviour to design the study and the framework method for the analysis. **Results** Seven themes explain implementation of prescribing recommendations in primary care: credibility of content, credibility of source, presentation, influential people, organisational factors, disease characteristics, and dissemination strategy. Change in recommendations may hinder implementation. This is important since the development of evidence-based guidelines requires change in recommendations. Practitioners do not have a universal view or a common understanding of valid 'evidence'. Credibility is improved if national bodies develop primary care guidelines with less input from secondary care and industry, and with simple and systematic presentation. Dissemination should target GPs' perceived needs, improve ownership and get things right in the first implementation attempt. Enforcement strategies should not be used routinely. **Conclusions** GPs were critical of guidelines' development, relevance and implementation. Guidelines should be clear about changes they propose. Future studies should quantify the relationship between evidence base of recommendations and implementation, and between change in recommendations and implementation. Small but important costs and side effects of implementing guidelines should be measured in evaluative studies.

Sherratt M, Andriychenko D, Walley T. Extent of uncollected prescriptions in general practice. *Primary Health Care Research and Development* 2007 8 326-32 DOI: 10.1017/S1463423607000412

A small number of prescriptions ordered by the patient from their general practice remain uncollected and hence undispensed. No research has been published on this phenomenon and on how this is managed. We aimed to evaluate this in one primary care trust. To find out what prescription items are not collected, and why. A descriptive cross-sectional

analysis of prescription data. Semi-structured interviews with 21 primary health care team members, and 10 patients who had apparently not collected their prescription. Fifty-seven patients from the lead author's practice were telephoned and gave their comments. Twenty general practices in the Gateshead Primary Care Trust. Nineteen practices provided suitable data for analysis from one month's uncollected prescriptions plus total items issued during the same period of time. All suitable patients who had uncollected prescriptions from 10 practices were invited to participate in a telephone interview. Similar patients from the lead author's practice were telephoned and invited to comment. On average 0.5% items were uncollected. Drugs for a specific diagnosis (eg, cardiovascular drugs) were significantly less likely to be uncollected than drugs prescribed either symptomatically or for a presumptive diagnosis (0.48% versus 0.67% uncollected, respectively, $P < 0.001$). Many uncollected prescriptions were due to administrative causes: few resulted from patient error or forgetfulness. The majority of patients reported obtaining their medication. No adverse events arising from uncollected prescriptions were reported. Uncollected prescriptions are a small proportion (0.5%) of the total issued and were more likely to be for non-essential items; therefore the policy of destroying uncollected prescriptions after an appropriate period without any further action is probably safe.

MENTAL HEALTH

Childs-Clarke A. Using cognitive behavioural therapy to treat common mental health problems in primary care. *Mental Health Practice* 2007 10 (9) 20-3.

Cognitive behaviour therapy (CBT) is recommended for a range of problems, including depression and anxiety, but patients seen in primary care with common mental health issues often present with co-morbidity and have psychosocial problems as well. It is not clear from the literature whether CBT will work with this range of difficulties. Adrian Childs-Clarke examines the effects of providing CBT for patients with common mental health problems in a primary care setting

Coelho H F, Canter P H, Edzard E. The effectiveness of hypnosis for the treatment of anxiety: a systematic review. *Primary Care and Community Psychiatry* 2007 12 (2)49-63. DOI: 10.1080/17468840701680678

Background & aim: Therapeutic hypnosis has been regaining popularity as an anxiety treatment in mainstream and alternative healthcare. This systematic review evaluates the effectiveness evidence from randomised clinical trials (RCTs) for both standalone and adjunctive hypnosis for the treatment of anxiety. Methods: Six electronic databases were searched from inception until February 2007. Reference lists of retrieved articles were hand-searched. There were no language restrictions. Two reviewers independently identified 14 RCTs of hypnosis for the treatment of anxiety, assessed trial quality, and extracted data. Where possible, between-group analyses were extracted or conducted for

this review using software from the Cochrane Collaboration (RevMan 4.2). Methodological heterogeneity of trials precluded meta-analysis. Data were synthesised in a narrative summary. Results: The contribution of many trials was limited by a lack of between-group analyses or because relevant statistical information was omitted. Between-group analyses presented in trial reports, and our own analyses, generally demonstrated no significant differences between hypnosis and control conditions (waiting list controls, contact controls, or other non-standard treatments). It is possible that non-significant findings were a result of small sample sizes. We did find some limited yet consistent evidence that hypnosis may be of benefit in alleviating test anxiety and performance-related social anxiety. Conclusions: The current RCT evidence is insufficient to support the use of hypnosis for treating anxiety. Given the lack of high quality trials in this area, the preliminary evidence of effectiveness for some anxiety types, and the regained popularity of hypnosis, further RCTs are warranted.

Dew K, et al. It puts things out of your control: fear of consequences as a barrier to patient disclosure of mental health issues to general practitioners *Sociology of Health and Illness* 2007 Online early paper 6/6/2007 DOI: 10.1111/j.1467-9566.2007.01022.x

Research indicates that there is a high level of trust in health professionals but also a high level of non-disclosure of mental health issues to general practitioners (GPs). This paper explores the issue of patients' willingness to disclose mental health problems to GPs through interviews with 33 patients from the lower half of the North Island of New Zealand. Patients' willingness to disclose related to a range of factors but this paper focuses on fear and sense of control as these issues have received little attention in the extant literature and provide important discussion points for the conduct of consultations. Fear of the consequences of consultation warrants attention if general practice is to be promoted as the preferred point of contact for mental health consultations. The research reported here suggests that trust in a range of institutions and agencies, not just in the individual practitioner, would need to be achieved for the GP to be the preferred point of contact.

Johnston O, et al. Qualitative study of depression management in primary care: GP and patient goals, and the value of listening. *British Journal of General Practice* 2007 57 (544) 872-9. DOI: 10.3399/096016407782318026

Background: Guidelines for depression management have been developed but little is known about GP and patient goals, which are likely to influence treatment offers, uptake, and adherence. Aim: To identify issues of importance to GPs, patients, and patients' supporters regarding depression management. GP and patient goals for depression management became a focus of the study. Design of study: Grounded theory-based qualitative study. Setting: GPs were drawn from 28 practices. The majority of patients and supporters were recruited from 10 of these practices. METHOD: Sixty-one patients (28 depressed, 18 previously depressed, 15 never depressed), 18 supporters, and 32 GPs were interviewed. Results: GPs described encouraging patients to view depression as separate from the self and 'normal' sadness. Patients and supporters often questioned such boundaries, rejecting the notion of a medical cure and emphasising self-management. The

majority of participants who were considering depression-management strategies wanted to 'get out' of their depression. However, a quarter did not see this as immediately relevant or achievable. They focused on getting by from day to day, which had the potential to clash with GP priorities. GP frustration and uncertainty could occur when depression was resistant to cure. Participants identified the importance of GPs listening to patients, but often felt that this did not happen. Conclusion: Physicians need greater awareness of the extent to which their goals for the management of depression are perceived as relevant or achievable by patients. Future research should explore methods of negotiating agreed strategies for management.

Junghan U M et al Staff and patient perspectives on unmet need and therapeutic alliance in community mental health services. *British Journal of Psychiatry* 2007 191 543-547 DOI: 10.1192/bjp.bp.107.037978

Background: Therapeutic alliance between clinicians and their patients is important in community mental healthcare. It is unclear whether providing effective interventions influences therapeutic alliance. Aims: To assess the impact of meeting previously unmet mental health needs on the therapeutic alliance between patients and clinicians. Method: Secondary analysis of data from a longitudinal study assessing 101 patients and paired staff. Results: Patient-rated unmet need was negatively associated with patient-rated and staff-rated therapeutic alliance. Staff-rated unmet need was positively associated with patient-rated therapeutic alliance only. Reducing patient-rated unmet need increased patient-rated but not staff-rated therapeutic alliance, even when controlling for other variables. Reducing staff-rated unmet need increased staff-rated but not patient-rated therapeutic alliance, but the effect became insignificant when controlling for other variables. Conclusions: Patient-rated therapeutic alliance will be maximised by focusing assessment and interventions on patient-rated rather than staff-rated unmet need.

Mc Call L, et al. Predictors of accuracy of recognition of emotional distress in general practice. *Primary Care and Community Psychiatry* 2007 12 (1) 1-6 DOI: 10.1080/17468840701560441

Aim: This study sought to determine factors associated with general practitioner (GP) recognition of emotional distress in Australian general practice. *Methods:* Twenty eight GPs completed a clinical audit in which they noted their identification of any emotional distress in their patients, while 868 of their patients completed the General Health Questionnaire (GHQ-28). The GHQ was scored with the conventional 4/5 cut-off. GP recognition was determined by a comparison of the GP record of emotional distress and the patient GHQ. Logistic regression was used to examine which patient and GP characteristics influenced correct recognition. *Results:* The GHQ identified 48% of all patients as probable cases. GPs identified 34% of their patients as having emotional distress, correctly recognizing 43% of GHQ cases. Overall, specificity was high (81%), though sensitivity was modest (43%). For individual GPs the rate of correct recognition varied considerably, from 4% to 100%. Correct recognition was associated with years experience as a GP, older age of patient and greater severity of distress. *Conclusions:* The data raise questions about the possible oversensitivity of the GHQ. The clinical skills associated with the recognition of mental illness and of emotional distress are obviously

complex, and take time and experience to develop. Reassuringly, GPs are recognising most of the more severe depressions.

McMahon L, et al Graduate mental health worker case management of depression in UK primary care: a pilot study. *British Journal of General Practice* 2007 57 (544) 880-5. DOI: 10.3399/096016407782317847

Background: Based on data from large multicentre US trials, the National Institute for Health and Clinical Excellence (NICE) is advocating a stepped-care model for the management of depression, with 'case management' or 'collaborative care' for selected patients in primary care. AIM: To conduct a pilot study examining the use of graduate mental health workers case managing depressed primary care NHS patients. Design of Study: A randomised controlled trial comparing usual GP care with or without case management over 16 weeks of acute antidepressant drug treatment. SETTING: Three primary care practices in the North East of England. Method: Patients with depression, aged 18-65 years, who had failed to adequately respond to antidepressant treatment, were randomised to the two treatments. Assessments were made at baseline, 12, and 24 weeks using a combination of observer and self ratings. Results: Randomisation of 62 patients required screening of 1073 potential patients. There was little difference in outcome between the two treatment arms but a gradual improvement in symptoms over time was seen. Client satisfaction was assessed as high across both treatments. Conclusion: While this pilot study confirmed the integrity of the study protocol and the suitability of the outcome measures and randomisation procedure, it raises questions regarding the practicality of recruitment and feasibility of the intervention. It would be crucial to address these issues prior to the implementation of a large multi-centre randomised controlled trial

Schreuders B, et al Primary care patients with mental health problems: outcome of a randomised clinical trial. *British Journal of General Practice* 2007 57 (544) 886-91. DOI: 10.3399/096016407782317829

Background: The prevalence of patients with mental health problems in general practice is high, and at least one-third of these problems last for 6 months or longer. Patients with these problems take up more time during a consultation and attend more frequently. AIM: This study investigated the effectiveness of problem-solving treatment for primary care patients with mental health problems. The hypothesis was that patients receiving problem-solving treatment from a nurse would have fewer symptoms after 3 months, or a lower attendance rate, compared with patients receiving the usual care from the GP. Design of the study: Randomised clinical trial. Setting: Twelve general practices in Amsterdam and 12 nurses from a mental healthcare institution. Method: A sample of patients aged ≥ 18 years were screened for mental health problems with the general health questionnaire (GHQ-12) in the waiting room of the general practices, and were randomised. Patients receiving the problem-solving treatment were required to complete four to six treatment sessions, while patients in the control group were treated as usual by the GP. Results: No significant difference was found between the groups in terms of improved psychopathology or a decrease in attendance rate. Post-hoc analyses showed a sub-group of patients with more severe pathology who may benefit from problem-solving

treatment. Conclusion: The main results show that problem-solving treatment provided by a nurse adds little to the usual care from the GP for frequent attenders with mental health problems. Post-hoc analyses show that there may be a sub-group of more severely depressed patients who could benefit from problem-solving treatment

NEED AND DEMAND FOR CARE

Hider P, et al Comparison of services provided by urban commercial, community-governed and traditional primary care practices in New Zealand. *Journal of Health Services Research and Policy* 2007 12 (4) 215-22. DOI: 10.1258/135581907782101525

Objectives: New Zealand has experienced restructuring and reform of primary health care since the 1980s, including the introduction of commercial clinics and increasing numbers of practices run by community-governed organizations. Our aim was to compare commercial, community-governed and traditional practices in five key domains: access; coordination and continuity of care; communication and patient centredness; population health and preventive health; and chronic disease management. Methods: A nationally representative, multistage probability sample of private general practitioners, stratified by geographical location and practice type, was drawn. Representative samples of urban commercial clinics and of practices governed by community organizations were obtained for the same period (2001-02). All doctors were asked to provide data on themselves, their practice, and to report on a 25% sample of patients in two periods of one week. Results: Among the three practice types, commercial clinics differed most in their organization; they charged higher fees and employed more staff, although their doctors were less experienced. Community-governed practices were visited by more people from lower socioeconomic groups. Commercial clinic patients were more likely to be younger and less likely to have an ongoing relationship with the clinic. They frequently attended for self-limiting problems related to injuries or respiratory problems. Investigations, follow-up and referral rates were similar between the three practice types. Treatment rates were higher at traditional and community-governed general practices. Conclusion: Rather than replicating traditional practices, new practice types provide complementary services and established services in innovative ways. The challenge is to achieve an appropriate mix of diverse providers

Horrocks S, Salmon D. Urgent care out of hours: a comparison of the experiences of older people and parents of young children in a semi-rural area. *Primary Health Care Research and Development* 2007 8 (4) 367-76. DOI: 10.1017/S1463423607000436

Older people and parents of young children are the most frequent users of out of hours care. However, their needs and expectations of care may be different. The aim of this study was to explore and compare the experiences and views of these two groups following the transfer of responsibility for out of hours services from General Practitioners (GPs) to a Primary Care Trust (PCT). Qualitative research using semi-structured interviews with 19 informants living in a geographically large, semi-rural PCT

area in England served by 15 GP practices. Interviews were taped, transcribed and analysed using a thematic framework. Older people presented with more complex health problems than young children, and expressed more reluctance at calling the service. Both groups experienced similar access problems for using the primary care centre (PCC). Older people reported fewer difficulties obtaining a home visit, though experienced continuity problems when illness episodes lasted longer than one shift. Both groups questioned the ability of a doctor to diagnose accurately using only telephone assessment. Despite differences in presenting symptoms and attitudes to service use, older people and parents with young children experienced similar problems in accessing care at the PCC. Older people more frequently received home visits than parents with young children, and it may be that social context is not sufficiently taken into account when assessing need for a home visit. Practitioners should be aware that older people tend to minimise symptoms and should be cautious of relying on lay interpretations of illness when carrying out telephone assessments with this group.

ORGANISATIONS

Cooke J, Mathers N, Mitchell C. Reciprocity and paying attention to process: an important issue for the UK Clinical Research Network in primary care? *Primary Health Care Research and Development* 2007 8 (4) 292-6. DOI: 10.1017/S146342360700045X

The Research & Development (R&D) strategy for health in the UK (Department of Health, 2006) has established an infrastructure of research networks, developed under the auspices of the UK Clinical Research Collaboration (UK CRC) and the National Institute for Health Research (NIHR), which, it is anticipated, will produce an efficient and effective interface between the NHS and academia to enable high quality clinical research. Such networks, among other things, aim to produce research for practice by supporting recruitment to clinical trials. This paper suggests some problems in relation to assumptions in this strategy, which imply that once networks have been established, the interface with practice is somehow 'sorted'. It explores particular issues for the primary care practice-research interface, where recruitment and capacity building have experienced significant barriers and difficulties in the past. The paper pays particular attention to valuing 'close to practice' principles in relation to the effectiveness of networks, and their ability to build capacity, and highlights the importance of process issues in achieving network aims. The paper highlights the experience and learning of existing networks in primary care, and evidence about what supports recruitment to clinical trials. The current lack of emphasis on developing research skills and leadership in frontline practitioners is also considered, and specific concerns regarding reciprocity between research and practice partnerships are highlighted. The need for development of such skills in non-clinical researchers is also important but not the subject of this paper. Concern is expressed that if these issues, and others related to the social capital of networks, are not addressed, then the UK Clinical Research Network (UKCRN) will not be able to deliver on its objectives.

Griffin BL, Gray J. Participatory appraisal: a tool for organisational planning and launching a virtual organisation. *Primary Health Care Research and Development* 2007 8 (4) 283-91. DOI: 10.1017/S1463423607000382

In 2003, Gateshead Primary Care Trust, England established a virtual Centre for Enabling Health Improvement (CEHI). The aims included support for the wider public health workforce and development of resources for health to enable allied professionals to improve the health of the people of Gateshead. In 2004, the CEHI steering group held a launch to provide a networking opportunity for staff. Participatory appraisal methods informed the workshops for the launch that aimed to throw light on the concerns of the public health workforce in their day-to-day working lives. Three participatory workshops were planned: a mapping workshop, a workshop about your working week and the timeline workshop. These aimed to find out from the 89 delegates what was special about their work, what the problems were and what were the solutions. The adoption of participatory methods underpinned one of CEHI's strategic goals namely, that the wider public health workforce would contribute to planning and shaping CEHI's future plans. The results illustrated the delegates' insight about special features of their work, for instance: valuing opportunities for multi-disciplinary working; issues such as inequalities in accessing services and solutions such as the provision of better integration of teams. The launch shaped a new approach to the delivery of public health in Gateshead by acknowledging and valuing the contribution of its public health workforce. The participatory workshops provided a positive experience for the delegates by contributing to the collection of information that formed the basis for future activities such as the organisation of networking events on current health topics including health needs assessment and lifestyle issues.

Kjekshus L, Hagen T. Do hospital mergers increase hospital efficiency? Evidence from a National Health Service country. *Journal of Health Services Research and Policy* 2007 12 (4) 230-5 DOI: 10.1258/135581907782101561

Objectives: To analyse the effects on technical and cost efficiency of seven hospital mergers over the period 1992-2000 in Norway. The mergers involved 17 hospitals. Methods: First, efficiency scores were generated using Data Envelopment Analysis for 53 merged and non-merged hospitals over the nine years. Second, the effect of mergers was estimated through panel data analysis. Results: In general, the mergers showed no significant effect on technical efficiency and a significant negative effect of 2-2.8% on cost efficiency. However, positive effects on both cost and technical efficiency were found in one merger where more hospitals were involved, and where administration and acute services were centralized. Conclusion: The findings indicate that large mergers involving radical restructuring of the treatment process may improve efficiency as intended, but most mergers do not

Nettleton S, Burrows R, Watt I. Regulating medical bodies? The consequences of the 'modernisation' of the NHS and the disembodiment of clinical knowledge. *Sociology of Health and Illness* 2007.

The aim of this paper is to explore the consequences of modernisation and regulatory processes for the everyday lives of doctors working the UK National Health Service. We do this by reporting on interview data generated as part of a qualitative investigation into the working lives of 47 doctors. The analysis of the empirical findings is informed by two literatures: that which has sought to theorise the contemporary thrust of regulation and audit and that which has developed a sociology of embodiment. Doctors' views are presented in relation to four areas of work which have - in the loosest sense of the word - been subject to regulation. Drawing on work from the sociology of embodiment we argue that changes in the institutional and cultural context of medical work could be altering both the 'field' and the 'habitus' - to use Bourdieu's terms - of medicine, with a consequence that medical knowledge is becoming less embodied.

PATIENT AND PUBLIC INVOLVEMENT

Brown CE, Roberts NJ, Partridge MR. Does the use of a glossary aid patient understanding of the letters sent to their general practitioner? *Clinical Medicine* 2007 7 (5) 457-260.

The NHS Plan suggests that all patients should be offered copies of letters regarding their treatment which are currently sent from a specialist clinic to their general practitioner (GP). Previous work has suggested that this enhances patient satisfaction, but medical letters can be difficult to understand. This report concerns the production and evaluation of a lung disease glossary to enhance patient understanding of terms used within the letter sent to their GP. Non-clinical staff reviewed 219 letters sent to GPs and words not likely to be understood by patients were listed and used to produce a glossary of 133 terms. One hundred and thirty-one participants from nine respiratory outpatient clinics in a London teaching hospital were sent the glossary and a questionnaire with their copy of the letter also sent to their GP. Of the 131 participants, 93 patients (71%) returned the questionnaire. Eighty-three (89%) found the glossary useful and the number of words checked ranged from 0 to 14 with a median of three words. Those who did not find the glossary useful explained that their understanding was already optimal or that the words they did not understand were not contained within the glossary. This was usually because the words related to non-respiratory comorbidities. This study confirms that the inclusion of a specialty specific glossary with the patients' copy of the letter being sent to their GP is appreciated by patients and appears to aid their understanding.

Cals JW, et al. Public beliefs on antibiotics and respiratory tract infections: an internet-based questionnaire study. *British Journal of General Practice* 2007 57 (545) 942-7. DOI: 10.3399/096016407782605027

Background: Patient expectations are among the strongest predictors of clinicians' antibiotic prescribing decisions. Although public knowledge, beliefs, and experiences of antibiotics contribute to these expectations, little is known about these public views. Aim: To gain insight into public knowledge, beliefs, and experiences of antibiotics and respiratory tract infections. Design of study: Cross-sectional, internet-based

questionnaire study. Setting: Members of the general public aged 16 years and over in the Netherlands. Methods: Public knowledge, beliefs, and experiences of antibiotics and respiratory tract infections, as well as predictors of accurate knowledge of antibiotic effectiveness, were measured using 20 questions with sub-items. The questionnaire was given to a Dutch community-based nationwide internet panel of 15 673 individuals. Of these, 1248 eligible responders were invited to participate; 935 responders (75%) completed the questionnaire. Results: Of the participants, 44.6% accurately identified antibiotics as being effective against bacteria and not viruses. Acute bronchitis was considered to require treatment with antibiotics by nearly 60% of responders. The perceived need for antibiotics for respiratory tract infection-related symptoms ranged from 6.5% for cough with transparent phlegm, to 46.2% for a cough lasting for more than 2 weeks. Conclusion: Public misconceptions on the effectiveness of, and indications for, antibiotics exist. Nearly half of all responders (47.8%) incorrectly identified antibiotics as being effective in treating viral infections. Doctors should be aware that unnecessary prescribing could facilitate misconceptions regarding antibiotics and respiratory tract infections. Expectations of receiving antibiotics were higher for the disease label 'acute bronchitis' than for any of the separate or combined symptoms prominently present in respiratory tract infection. Public beliefs and expectations should be taken into account when developing interventions targeting the public, patients, and physicians to reduce unnecessary prescribing of antibiotics for respiratory tract infections.

Martin GP. Ordinary people only: knowledge, representativeness, and the publics of public participation in healthcare. *Sociology of Health and Illness* 2007. Online Early Paper DOI: 10.1111/j.1467-9566.2007.01027.x

Public involvement in healthcare is a prominent policy in countries across the economically developed world. A growing body of academic literature has focused on public participation, often presenting dichotomies between good and bad practice: between initiatives that offer empowerment and those constrained by consumerism, or between those which rely for recruitment on self-selecting members of the public, and those including a more broad-based, statistically representative group. In this paper I discuss the apparent tensions between differing rationales for participation, relating recent discussions about the nature of representation in public involvement to parallel writings about the contribution of laypeople's expertise and experience. In the academic literature, there is, I suggest, a thin line between democratic justifications for involvement, suggesting a representative role for involved publics, and technocratic ideas about the potential 'expert' contributions of particular subgroups of the public. Analysing recent policy documents on participation in healthcare in England, I seek moreover to show how contemporary policy transcends both categories, demanding complex roles of involved publics which invoke various qualities seen as important in governing the interface between state and society. I relate this to social-theoretical perspectives on the relationship between governmental authority and citizens in late-modern society.

PRIMARY/SECONDARY CARE INTERFACE

Enthoven AC, Crosson FJ, Shortell SM. 'Redefining health care': medical homes or archipelagos to navigate? *Health Affairs (Millwood.)* 2007 26 (5) 1366-72. DOI: 10.1377/hlthaff.26.5.1366 DOI: 10.1377/hlthaff.26.5.1366

This paper provides an analysis of the structure of the health care delivery system, emphasizing physician group practices. The authors argue for comprehensive integrated delivery systems (IDSs). The jumping-off point for their analysis is the recently published *Redefining Health Care: Creating Value-Based Competition on Results*, by Michael Porter and Elizabeth Teisberg. The authors focus on the book's core idea that competitors should be freestanding integrated practice units (or "islands in archipelagos") versus IDSs (or "medical homes"). In any case, the authors contend that this issue should be resolved by competition to attract and serve informed, cost-conscious, responsible consumers on a level playing field

Hoskins R, Gow A, McDowell J. Corporate solutions to caseload management - an evaluation. *Community Practitioner* 2007 80 (9) 20-4.

This paper describes an evaluation of a change in health visiting service delivery from GP caseload management to corporate caseload working, in one inner city health centre located in a deprived area of Glasgow. The aim of the study was to identify if moving to corporate caseload working provides the reported benefits cited in the limited literature available. A purposive sample consisting of ten health visitors, one GP, one manager and three clients volunteered to participate in this mixed methods evaluation study. Data were collected by means of a stress questionnaire, public health nursing diary, focus groups and semi-structured interviews. Findings show that immediate improvements were seen in team working, staff communication, sharing practice, enhanced clinical reflection and standards of documentation. However, corporate caseload working did not appear to reduce staff stress levels, increase public health nursing activity or improve quality of client service. Further research conducted over a longer time period with a full staffing complement is needed to validate these findings.

Ionescu-Ittu R, et al. Continuity of primary care and emergency department utilization among elderly people. *Canadian Medical Association Journal* 2007 177 (11) 1362-8 DOI: 10.1503/cmaj.061615

Background: People aged 65 years or more represent a growing group of emergency department users. We investigated whether characteristics of primary care (accessibility and continuity) are associated with emergency department use by elderly people in both urban and rural areas. Methods: We conducted a cross-sectional study using information for a random sample of 95,173 people aged 65 years or more drawn from provincial administrative databases in Quebec for 2000 and 2001. We obtained data on the patients' age, sex, comorbidity, rate of emergency department use (number of days on which a

visit was made to an emergency department per 1000 days at risk [i.e., alive and not in hospital] during the 2-year study period), use of hospital and ambulatory physician services, residence (urban v. rural), socioeconomic status, access (physician: population ratio, presence of primary physician) and continuity of primary care. Results: After adjusting for age, sex and comorbidity, we found that an increased rate of emergency department use was associated with lack of a primary physician (adjusted rate ratio [RR] 1.45, 95% confidence interval [CI] 1.41-1.49) and low or medium (v. high) levels of continuity of care with a primary physician (adjusted RR 1.46, 95% CI 1.44-1.48, and 1.27, 95% CI 1.25-1.29, respectively). Other significant predictors of increased use of emergency department services were residence in a rural area, low socioeconomic status and residence in a region with a higher physician:population ratio. Among the patients who had a primary physician, continuity of care had a stronger protective effect in urban than in rural areas. Interpretation: Having a primary physician and greater continuity of care with this physician are factors associated with decreased emergency department use by elderly people, particularly those living in urban areas

QUALITY OF CARE

Abbott S, Procter S, Iacovou N. Models for quality improvement and assurance in English and Welsh primary care. *Primary Health Care Research and Development* 2007; 8 (4) 297-307. DOI: 10.1017/S1463423607000345

Various initiatives have been tried to improve the quality of primary care in England and Wales in the last fifteen years. Such initiatives can be divided into quality improvement (QI) and quality assurance (QA). This paper looks at three contrasting models, drawn from data from 48 semistructured interviews with personnel from three primary care organisations (PCOs): two primary care trusts in England and one Local Health Board in Wales. The first model was collegiate, a voluntary doctor-led initiative begun during the period of GP fundholding. The second is clinical governance, a current government-imposed system administered by PCO officers, which has attracted limited engagement from GPs. The third is the Quality and Outcomes Framework of the new GP contract, which was generally described positively, although the process of administering it was experienced as bureaucratic. The three models correspond with three organisational types: networks (which use peer relationships to achieve goals), hierarchy (which use 'top-down' requirements and monitoring) and market (which use contracts). Although doctors have traditionally preferred network-style arrangements, the success of these arrangements in sustained QA and QI has been questionable. The importance of hierarchical arrangements is inevitable, given the functions and constitution of PCOs, and the risk that GPs will disengage is similarly inevitable. However, it is important that PCO officers find ways to engage GPs as much as possible in quality initiatives if patient services are to improve.

Cahill P, Papageorgiou A. Triadic communication in the primary care paediatric consultation: a review of the literature. *British Journal of General Practice* 2007 57 (544) 904-11. DOI; 10.3399/096016407782317892

Background: Children aged 6-12 years are usually seen in primary care with an adult carer. It is a government and professional priority for doctors to try and involve these children in their medical consultations. Aim: To ascertain the evidence available on the amount and type of involvement that children in the 6-12 year age group have in their primary care consultations when the consultation was held with a child, a GP, and an adult. Design of the study: Literature review. Method: Data sources included MEDLINE, CINAHL, EMBASE, and ERIC, The Cochrane library, PsychINFO, Web of Science and Wilson's Social Science abstracts, hand searching for references, and contact with authors. Results: Twenty-one studies were selected for inclusion in the study. Children were found to have little quantitative involvement in their own consultations. They may take part during information gathering but are unlikely to participate in the treatment planning and discussion parts of the consultation. Conclusion: Children in the 6-12 year age group have little meaningful involvement in their consultations

Cahill P, Papageorgiou A. Video analysis of communication in paediatric consultations in primary care. *British Journal of General Practice* 2007 57 (544) 866-71. DOI; 10.3399/096016407782317838

Background: There is a paucity of research evidence concerning communication in paediatric consultations between GPs, adults, and child patients. Aim: This study was carried out to identify features of the interaction between a doctor, a child patient aged 6-12 years, and their carer in the consultation associated with the child's participation. Design of study: A qualitative analysis of video recordings of 31 primary care paediatric consultations was undertaken, using strategies from the methodology of conversation analysis. Setting: Primary care, Suffolk, UK. Method: NHS GPs from three primary care trusts (PCTs), were invited to participate in this study. Sixteen volunteers from this sample took part. Results: Analysis of the interaction in the consultations revealed that the children had little involvement. Children participated when invited to do so, and took more time than adults to answer a doctor's question. An adult carer was less likely to answer on behalf of a child, when they were in a position to see that the doctor's gaze was directed at the child, and the doctor addressed the child by name. Adult carers, who had not voiced their own concerns first, were seen to interrupt doctor-child talk. In consultations where the participants sat in a triangular arrangement, all parties being an equal distance apart, triadic talk was noted. Conclusion: Child involvement in the primary care consultation is associated with adult carers being able to voice their own concerns early in the consultation, and children being invited to speak with the appropriate recipient design

Coleman A. Working jointly to scrutinize health. *Journal of Integrated Care* 2007 15 (5) 26-33.

What difference is the operation of local authority health scrutiny making to the oversight and democratisation of decision making by health bodies? This article provides an insight into how a group of local authorities in England tackled the operation of a specific joint health scrutiny committee. This example highlights building relations with associated health bodies and other local authorities, choice of health scrutiny agenda, ways of working, capacity of committees, ambiguities within the policy itself, and the difficulties and challenges of adding meaningful democratic oversight to the decision-making processes of NHS bodies. This review highlights some of the benefits of health scrutiny, but suggests that engaging more fully with patients and the public in such reviews could result in a more influential and inclusive process.

Downing A, et al. Do the UK government's new Quality and Outcomes Framework (QOF) scores adequately measure primary care performance? A cross-sectional survey of routine healthcare data. *BMC Health Services Research* 2007 7 (1) 166 DOI: 10.1186/1472-6963-7-166

Background: General practitioners' remuneration is now linked directly to the scores attained in the Quality and Outcomes Framework (QOF). The success of this approach depends in part on designing a robust and clinically meaningful set of indicators. The aim of this study was to assess the extent to which measures of health observed in practice populations are correlated with their QOF scores, after accounting for the established associations between health outcomes and socio-demographics. Methods: QOF data for the period April 2004 to March 2005 were obtained for all general practices in two English Primary Care Trusts. These data were linked to data for emergency hospital admissions (for asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, stroke and all other conditions) and all cause mortality for the period September 2004 to August 2005. Multilevel logistic regression models explored the association between health outcomes (hospital admission and death) and practice QOF scores (clinical, additional services and organisational domains), age, sex and socio-economic deprivation. Results: Higher clinical domain scores were generally associated with lower admission rates and this was significant for cancer and other conditions in PCT 2. Higher scores in the additional services domain were associated with higher admission rates, significantly so for asthma, CHD, stroke and other conditions in PCT 1 and cancer in PCT 2. Little association was observed between the organisational domain scores and admissions. The relationship between the QOF variables and mortality was less clear. Being female was associated with fewer admissions for cancer and CHD and lower mortality rates. Increasing age was mainly associated with an increased number of events. Increasing deprivation was associated with higher admission rates for all conditions and with higher mortality rates. Conclusions: The associations between QOF scores and emergency admissions and mortality were small and inconsistent, whilst the impact of socio-economic deprivation on the outcomes was much stronger. These results have implications for the use of target-based remuneration of general practitioners and

emphasise the need to tackle inequalities and improve the health of disadvantaged groups and the population as a whole.

Dyas J, Bethea J, Jones M. Identifying consensus on the appropriate advice for managing common childhood illnesses: a nominal group study. *Quality In Primary Care* 2007 15 (5) 285-92.

Background: Consultation rates in the UK for children aged 0-4 years are high and may be rising due to increased consultations for minor illness. It has been reported that parents lack confidence when making decisions on how to manage common childhood illnesses and that advice received from healthcare professionals is not always consistent. Objective: The objective of the study was to identify advice and information that should be given to parents or carers around the management of common childhood illnesses that is agreed upon by a range of primary healthcare professionals. Methods: The nominal group technique was used to identify items of advice that could be given to parents/carers relating to the management of common childhood illness. Forty-eight primary care professionals replied to an open question letter on what clinical advice they gave to parents, how to reduce parental anxieties in the consultation and how best to relay advice outside the consultation. The responses to this survey were developed into a 97-item questionnaire that would form the basis of the nominal group discussion. Two parents and seven primary care professionals were then recruited to take part in the nominal group. Prior to the group session, participants were asked to complete the 97-item questionnaire. Analysis was done to identify any pre-existing consensus and then a highly facilitated group discussion was held where group members were asked to discuss items where consensus had not been reached. During this discussion the participants re-rated the questionnaire items, and the analysis to identify consensus was repeated. Results: There was a lack of consensus for many of the questionnaire items considered by the group members. Prior to the group discussion, consensus was reached on seven questionnaire items relating to the clinical management of common childhood illness. Following the group discussion, consensus was reached for a further 12. Items where consensus was reached included advice such as: 'If a child has a sore throat a standard dose of oral paracetamol or ibuprofen should be given as indicated on the bottle'. Conclusion: There was a lack of consensus on many of the questionnaire items that were discussed by the nominal group members. This may have implications for the consistency and hence quality of advice that is provided by the primary care team around the appropriate management of common childhood illness. It is recommended that primary care teams focus on providing advice on which there was consensus, as a means of generating greater consistency and improving the quality of management of childhood illnesses in primary care.

Edwards A, Langley A. Understanding how general practices addressed the Quality and Outcomes Framework of the 2003 General Medical Services contract in the UK: a qualitative study of the effects on quality and team working of different approaches used. *Quality In Primary Care* 2007 15 (5) 265-76.

Background: The introduction of the 2003 General Medical Services (GMS) contract was one of the largest and most fundamental changes to UK general practice, and presented

particular challenges with its target-driven approach. Practices are thought to have used a variety of ways to address these challenges, including organisational changes and incentive schemes, but their relative success and impact on team working and morale in practices is not well understood or described. Aim: To identify how practices addressed the Quality and Outcomes Framework of the general practice contract, in particular the nature and degree to which incentive schemes were used, and to explore their perceived influence on team working and staff morale within the practices. Design: Qualitative study using semi-structured interviews with the practice managers, after the first year of contract implementation. Setting: Fourteen general practices in Gwent, South Wales. Methods: Interviews were based on eight aspects of team climate, digitally recorded and transcribed for content analysis. Results: Increased workloads due to the introduction of the new contract affected team working and morale, although generally teams accepted change. Some motivational advantages were found in some practices using team incentives, but in others perceived unfairness of incentive schemes caused resentment and contributed to staff leaving practices. Increasing team size, involvement of the team in change, and good leadership were also found to motivate the team, and were perceived to have improved quality of care, regardless of motivational methods. Conclusions: Management of change requires careful planning and implementation. Incentive schemes have some benefits but also present difficulties. These effects can be interpreted in the context of organisational and occupational literature, which offers frameworks for understanding which methods of motivation and achieving change may be most advantageous.

Essex B, Ashworth M, Crichton N. Performance concerns in primary care: a Delphi consensus on risk and investigation. *Quality In Primary Care* 2007 15 (5) 293-300.

Background: There is little agreement on the risks that concerns about the performance of general practitioners present to patients in primary care or how they should be investigated. This may result in a lack of consistent decisions about the management of serious concerns, and has implications for patient safety. Aim: To develop a set of criteria for assessment of risk to patients and for investigating performance concerns in general practice. Design: Two-round Delphi questionnaire. Methods: Panellists were medical and non-medical people with extensive experience of assessing, investigating and managing performance concerns in primary care. Panellists were presented with scenarios about performance concerns, together with one of five possible investigation options: a medical record review, prescribing system review, practice-management assessment, GP suspension hearing or a death review. They then considered 95 scenarios, rating 69 according to risk and all 95 according to investigation options. In the second round, ratings were repeated after panellists had reviewed their own and group first-round responses. Consensus was defined in advance as 80% of responses in the upper third on a nine-point rating scale. Results: Consensus on high risk was achieved for 36 of the 69 (52%) risk scenarios. Consensus on the proposed investigation was achieved in 33 of the 95 (35%) investigation scenarios. Conclusions: This is the first study to report the development of consensus on the nature of performance concerns that pose a high risk to patients, and about their appropriate investigation in primary care. We have identified a series of high-risk performance concerns and linked these to appropriate methods of

investigation. The management of performance concerns should be guided by explicit consensus criteria to improve the quality of decision making in managing poor performance in primary care. Patient safety may be compromised by inconsistent management of performance concerns.

**Ferris TG, et al Physician specialty societies and the development of physician performance measures. *Health Affairs (Millwood.)* 2007 26 (6) 1712-9
DOI: 10.1377/hlthaff.26.6.1712**

Efforts to increase accountability in the delivery of care include attempts to measure performance of individual doctors. Although physician specialty societies may be best positioned to define best practices, they have not yet played a major role in the development of measures. We examined specialty society involvement in measure development through interviews and review of Web sites. We found that a minority (35 percent) of societies were engaged in developing performance measures. Key barriers included member reluctance, lack of resources for development, and problems with data collection; facilitators included strong leadership and the perception of increasing pressure for accountability

Glynn RJ, et al. Design of cluster-randomized trials of quality improvement interventions aimed at medical care providers. *Medical Care* 2007 45 (10) S38-S43. DOI: 10.1097/MLR.0b013e318070c0a0

Background: Randomized trials aimed at improving the quality of medical care often randomize the provider. Such trials are frequently embedded in health care systems with available automated records, which can be used to enhance the design of the trial. Methods: We consider how available information from automated records can address each of the following concerns in the design of a trial: whether to randomize individual providers or practices; clustering of outcomes among patients in the same practice and its impact on study size; expected heterogeneity in adherence and the response to the intervention; eligibility criteria and the trade-offs between generalizability and internal validity; and blocking or matching to alleviate covariate imbalance across practices. Results: Investigators can use available information from an automated database to estimate the amount of clustering of patients within providers and practices, and these estimates can inform the decision on whether to randomize at the level of the patient, the provider, or the practice. We illustrate calculation of the anticipated design effect for a proposed cluster-randomized trial and its implications for sample size. With available claims data, investigators can apply focused eligibility criteria to exclude subjects and providers with expected low compliance or lower likelihood of benefit, although possibly at some loss of generalizability. Chance imbalances in covariates are more likely when randomization occurs at the level of the practice than at the level of the patient, so we propose a matching score to limit such imbalances by design. Conclusions: Challenges to compliance, expected small effects, and covariate imbalances are particularly likely in cluster-randomized trials of quality improvement interventions. When such trials are embedded in medical systems with available automated records, use of these data can enhance the design of the trial.

Jabaaij L et al Recently enlisted patients in general practice use more health care resources *BMC Family Practice* 29/11/2007 8:64 DOI: 10.1186/1471-2296-8-64

Background The continuity of care is one of the cornerstones of general practice. General practitioners find personal relationships with their patients important as they enable them to provide a higher quality of care. A long-lasting relationship with patients is assumed to be a prior condition for attaining this high quality. We studied the differences in use of care between recently enlisted patients and those patients who have been enlisted for a longer period. **Methods** 104 general practices in the Netherlands participated the study. We performed a retrospective cohort study in which patients who have been enlisted for less than 1 year (n=10,102) were matched for age, sex and health insurance with patients who have been enlisted for longer in the same general practice. The two cohorts were compared with regard to the number of contacts with the general practice, diagnoses, rate of prescribing, and the referral rate in a year. These variables were chosen as indicators of differences in the use of care. **Results** In the year following their enlistment, a higher percentage of recently enlisted patients had at least one contact with the practice, received a prescription or was referred. They also had a higher probability of receiving a prescription for an antibiotic. Furthermore, they had a higher mean number of contacts and referrals, but not a higher mean number of prescriptions. **Conclusions** Recently enlisted patients used more health care resources in the first year after their enlistment compared to patients enlisted longer. This could not be explained by differences in health.

Lester H, Roland M. Future of quality measurement. *British Medical Journal* 2007 335 1130-1. DOI: doi:10.1136/bmj.39385.406192.AD

In the past decade there has been sustained international interest in measuring quality of care. In the United Kingdom, quality indicators with financial incentives to reward good care were introduced as a result of increasing awareness of variable quality in primary care, the technical feasibility of introducing evidence based indicators within information technology systems, and a resolve by political negotiators to use improved quality to secure additional investment in primary care. Similar but less comprehensive initiatives have been introduced in the United States, Europe, Australia, and New Zealand. However, as this series has shown, the use of quality measures has also created controversy. Our view is that using incentives to improve quality of care has been beneficial. We look at what needs to be done to ensure those benefits remain in the future.

Majeed A, Lester H, Bindman AB. Improving the quality of care with performance indicators. *British Medical Journal* 2007 335 (7626) 916-8. DOI: 10.1136/bmj.39337.539120.AD

The quality of services provided by primary care doctors varies widely, and there is often a large gap between optimal primary care services and actual practice. This quality gap

can have serious health consequences, including deaths from medical errors, increased rates of complications in chronic disease, hospital admissions for adverse drug reactions and interactions, and outbreaks of potentially preventable infectious diseases such as measles. It also has large financial costs for the healthcare system, national governments, and society, as well as affecting patients' quality of life. The reasons for the quality gap are not always within the doctors' control. Sometimes the cause can lie with the public—for example, parents who refuse to allow their child to receive the measles, mumps, and rubella vaccine because of concerns about side effects

Nicolai J, Demmel R. The impact of gender stereotypes on the evaluation of general practitioners' communication skills: An experimental study using transcripts of physician–patient encounters. *Patient Education and Counseling* 2007 69 (1-3) 200-5. DOI: 10.1016/j.pec.2007.08.013

Objective The present study has been designed to test for the effect of physicians' gender on the perception and assessment of empathic communication in medical encounters. **Methods** Eighty-eight volunteers were asked to assess six transcribed interactions between physicians and a standardized patient. The effects of physicians' gender were tested by the experimental manipulation of physicians' gender labels in transcripts. Participants were randomly assigned to one of two testing conditions: (1) perceived gender corresponds to the physician's true gender; (2) perceived gender differs from the physician's true gender. Empathic communication was assessed using the Rating Scales for the Assessment of Empathic Communication in Medical Interviews. **Results** A 2 (physician's true gender: female vs. male) × 2 (physician's perceived gender: female vs. male) × 2 (rater's gender: female vs. male) mixed multivariate analysis of variance (MANOVA) yielded a main effect for physician's true gender. Female physicians were rated higher on empathic communication than male physicians irrespective of any gender labels. **Conclusion** The present findings suggest that gender differences in the perception of physician's empathy are not merely a function of the gender label. These findings provide evidence for differences in male and female physicians' empathic communication that cannot be attributed to stereotype bias. **Practice implications** Future efforts to evaluate communication skills training for general practitioners may consider gender differences.

Rodriguez H P, et al. Patient Samples for Measuring Primary Care Physician Performance: Who Should Be Included? *Medical Care* 2007 45 (10) 989-96. DOI: 10.1097/MLR.0b013e318074ce63

Background: In measuring patients' experiences with individual primary care physicians (PCPs), the reliability and validity of data based on samples of "established" patients of a physician's panel have been shown. However, as large-scale initiatives seek the least costly approach to obtaining these data, little is known about the implications of expanding samples to include any patient who has seen the physician in the relevant time period. **Methods:** A brief validated patient questionnaire was administered to a random sample of patients visiting 67 PCPs in California between January and October 2005. We evaluated the concordance between administrative and patient-reported information on whether the physician was the patient's PCP. Response rates, data quality, and

experiences reported by confirmed "established" patients were compared with those of "unestablished" patients.

Results: Administrative data designating patients as established to a PCP were highly concordant with patient self-report (96.5%). For unestablished patients, concordance was considerably lower (40.0%). Response rates among established patients were higher than those of patients believed to be unestablished (35.5% vs. 22.2%). Compared with established patients of a PCP's practice, unestablished patients reported significantly less favorable experiences with the doctor (interaction quality, $P < 0.001$; health promotion, $P < 0.001$; access, $P < 0.001$; integration, $P < 0.05$). The ranking of individual physicians differed for established and unestablished patient samples. Conclusions: Initiatives measuring patients' experiences with individual primary care physicians will achieve different results (response rates, physician scores) if samples include any patient who has seen the physician versus those whom administrative data indicate as established members of the physician's panel.

Wells K B, et al. The cumulative effects of quality improvement for depression on outcome disparities over 9 years: results from a randomized, controlled group-level trial. *Medical Care* 2007 45 (11) 1052-9 DOI: 10.1097/MLR.0b013e31813797e5

Background: Quality improvement (QI) programs for depression can improve outcomes of care and reduce outcome disparities; but cumulative effects on mental health outcome disparities have seldom been evaluated. Objective: To estimate cumulative effects over many years of short-term QI programs for depression in primary care on mental health outcome disparities, and to develop an interpretation for annualized, cumulative mental health outcome scores. Design: We conducted a group-level, randomized controlled trial in 6 US healthcare organizations. The QI programs supported provider and patient education in depression treatment and resources for medication management (QI-Meds) or access to evidence-based psychotherapy (QI-Therapy). Sites were selected to oversample minorities. Patients: Results were extrapolated to 1188 initially enrolled and living patients depressed at baseline. Main Outcome: Psychologic well-being (MHI-5) estimated as cumulative outcomes and outcome disparities (minority-whites) over 9 years, and annualized. Results: Across analyses there was a significant interaction of intervention status and ethnicity [lowest $F(2,160) = 4.96$, $P = 0.008$]. QI-therapy improved cumulative outcomes among minorities (mean, 37.92-44.29 MHI-5 points) and reduced outcome disparities for the whole sample relative to usual care (UC) (by mean, 39.44-59.01 MHI-5 points) and relative to QI-Meds (by mean, 53.90-74.41 MHI-5 points), lowest $t(103) = 3.12$, $P = 0.002$. By comparison, UC patients who lost a loved one in the year after baseline had lower psychologic well being by 6.18 MHI-5 scale points compared with similar UC patients without such a loss [$t(15)=2.52$, $P = 0.02$]. Conclusions: QI programs incorporating support for evidence-based psychotherapy offer an approach to substantially reduce cumulative outcome disparities for depressed primary care patients.

RESEARCH AND DEVELOPMENT

Murray S, Buller AM. Exclusion on grounds of language ability - a reporting gap in health services research? *Journal of Health Services Research and Policy* 2007 12 (4) 205-8. DOI: 10.1258/135581907782101642

Background: Health services research practices in the context of ethnic and cultural diversity are under scrutiny. One issue that needs to be considered is that of inclusion in, and exclusion from, research studies on the basis of language ability. We explore current reporting practice concerning recruitment of participants in health services research using examples from one 'high impact' journal and suggest ways in which future reporting can be strengthened. Methods: Retrospective review of 207 'original research pieces' published in the BMJ. Inclusion criteria: articles published in 2003 and 2004 reporting research entailing direct communication between a researcher and health service users. A data extraction checklist was applied concerning the reporting of language-related decisions in recruitment. Results: Eighty-four percent of the research articles did not engage with language issues at all. For most papers it was impossible to ascertain whether research was carried out in a monolingual population or whether researchers had effectively excluded non-primary language speakers in their recruitment procedures. Over half (n = 34) of the papers that mentioned language did so in relation to exclusion criteria, usually without further comment. Conclusions: Reporting practice on language-related decisions in recruitment and on the exclusion of research participants on grounds of language ability needs to be improved. A checklist for authors, reviewers or editors is offered with the aim of encouraging fuller reporting on the language composition of source and sample populations, and greater consideration of any implications that exclusion/inclusion on the grounds of language may have for studies and their findings

Shaw S E. Driving out alternative ways of seeing: the significance of neo-liberal policy mechanisms for UK primary care research. *Social Theory and Health* 2007 5 (4) 316-37. DOI: 10.1057/palgrave.sth.8700102

Health research involves more than the simple generation and use of knowledge and should be considered as a political exercise laden with power relations and strategies for gain. Health research and related policy are pushed and pulled in different directions according to the priorities identified by particular institutions and individuals. I explore the means by which one such area - primary care research - is governed and regulated, by whom, for what potential gain, and to what ends. I employ discourse analysis as a means of appreciating the social and historical contingency of research and the power relations inherent within it and import the theoretical concept of 'governmentality' to situate analysis within the context of neo-liberal politics (a distinct government rationality associated with free-market ideology allowing political objectives to be achieved through 'action at a distance'). Findings show how the relationship between science and government has promoted managerial approaches to the organization and conduct of

primary care research manifest in a number of policy mechanisms. These aid standardization of activities and encourage researchers and the organizations in which they are based to take on particular types of research production and practices to the exclusion of others.

RESEARCH METHODS

Atkins D. Creating and synthesizing evidence with decision makers in mind: integrating evidence from clinical trials and other study designs. *Medical Care* 2007;45 (10) S16-S22. DOI: 10.1097/MLR.0b013e3180616c3f

Background: Randomized controlled trials (RCTs) remain the accepted "gold standard" for determining the efficacy of new drugs or medical procedures. Randomized trials alone, however, cannot provide all the relevant information decision makers need to determine the relative risks and benefits when choosing the best treatment of individual patients or weighing the implications of particular policies affecting medical therapies. Objectives: To demonstrate the limitations of RCTs in providing the information needed by medical decision makers, and to show how information from observational studies can supplement evidence from RCTs. Methods: Qualitative description of the limitations of RCTs in providing the information needed by medical decision makers, and demonstration of how evidence from additional sources can aid in decision making, using the examples of deciding whether a 60-year-old woman with mildly elevated blood pressure should take daily low-dose aspirin, and whether a hospital network should implement carotid artery surgery for asymptomatic patients. Conclusions: Even the most rigorously designed RCTs leave many questions central to medical decision making unanswered. Research using cohort and case-control designs, disease and intervention registries, and outcomes studies based on administrative data can all shed light on who is most likely to benefit from the treatment, and what the important tradeoffs are. This suggests the need to revise the traditional evidence hierarchy, whereby evidence progresses linearly from basic research to rigorous RCTs. This revised hierarchy recognizes that other research designs can provide important evidence to strengthen our understanding of how to apply research findings in practice.

Orzano AJ, et al. Strategies for conducting complex clinical trials in diverse community practices. *Medical Care* 2007 45 (12) 1221-6. DOI: 10.1097/MLR.0b013e31814847a0

Background:: Closing the gap between evidence and practice demands interventions targeting the whole practice. These system level interventions require more complex designs and require greater practice involvement. Current descriptions of trials use research designs that either limit practice involvement or make use of large health system resources. Objective:: To share insights on retention of practices in a complex clinical trial aimed at improving care of multiple chronic conditions in 60 diverse community primary care practices not supported by large health system resources. Research Design::

Qualitative cross case analysis of field notes from meetings of a diverse research team. Results:: Five interrelated factors were found to be important to the success of the study implementation process: (1) developing structure and activities for relationship building; (2) attention to consistent communication; (3) timely information sharing; (4) evolution of a cross-functional research team; (5) provision of technical assistance. Specific strategies were identified to overcome challenges to study implementation. Conclusions:: Diverse community primary care practices without support from health system resources will complete participation in complex trials. Researchers need not avoid answering questions requiring complex study designs; however, successful implementation requires an individualized approach tailored to the needs and characteristics of each practice

SERVICE ORGANIZATION AND DELIVERY

Aldred R. Community governance or corporate governance? Two models for primary care provision in England. *Social Theory and Health* 2007;5 (4) :338-55. doi: 10.1057/palgrave.sth.8700109

This article discusses two models of primary care provision in England: a now-dominant corporate-led approach and a voluntary-led approach. Recent case study data are used to identify the differing implications of these contrasting ways of organizing care. The two approaches are examined with reference to claims that neoliberal welfare is characterized by a parallel shift from 'passive' to 'active' welfare, or from the citizen as recipient to the citizen as participant. In this analysis, the individualized, privatized self is encouraged by - and supports - a privatized welfare regime. By contrast, this paper finds that the increasingly hegemonic corporate-led model of welfare can actually inhibit the development of service users into active citizens. Instead, a voluntary-led model may be more flexible and more likely to promote welfare systems with citizen participation. However, the corporate-led model is increasingly favoured by the UK government, which is keen to include such firms in service planning as well as service provision. This creates a disjuncture between economics and governance that causes rhetorical and practical problems for neoliberal welfare regimes.

WORKFORCE

Gervais J, Starfield B, Violan C, Minue S. GPs with special interests: unanswered questions. *British Journal of General Practice* 2007 57 (544) 912-7. DOI: 10.3399/096016407782317865

The NHS Plan signalled the creation of GPs with special interests (GPwSIs) in the UK. The role of a GPwSI involves the acquisition of knowledge and skills that enable GPs to dedicate a portion of their time to performing the role of consultants to their colleagues within the ambit of general practice, and with respect to specific health problems encountered. The objectives behind the introduction of GPwSIs are to improve the

patient's access to specialist care, to cut waiting-list times, and to save on referral costs, (and as a consequence to increase the prestige of the GPs involved). However, the reality may not meet these expectations. Before accepting the proposition for universal implementation of GPwSIs empirical evidence is required to demonstrate that overall health is improved (of patients as well as the population); patients, especially patients of doctors working alone or in small groups (specifically in rural areas) are not disadvantaged; referral is improved and made more appropriate to the requirements of patients and their health problems; real prestige is generated, not only among GPs and students, but also among patients; biological views typical of the specialist are not promoted; and a brake is not applied to other alternatives in, or the reorganisation of, primary care.

Hussey P. International migration patterns of physicians to the United States: A cross-national panel analysis. *Health Policy* 2007 84 (2-3) 298-307. DOI: 10.1016/j.healthpol.2007.04.005

Objectives To analyze the dynamics of physician international migration patterns and identify the countries deviating most from expected migration rates. **Methods** A negative binomial log-linear model of physician migration to the United States from every other country was constructed using a panel of country-level data for years 1994-2000. The model was used to identify factors associated with physician migration and to identify countries with higher or lower rates of physician migration than expected. **Results** Physician migration varied with a country's GDP per capita in an inverse-U pattern, with highest migration rates from middle-income countries. The absence of medical schools, immigrant networks in the United States, medical instruction in English, proximity to the United States, and the lack of political and civil liberties were also associated with higher migration rates. Countries with higher-than-predicted migration rates included Iceland, Albania, Armenia, Dominica, Lebanon, Syria, the United Arab Emirates, and Bulgaria. Countries with lower-than-predicted migration rates included Mexico, Japan, Brazil, Zimbabwe, Mauritania, Portugal, Senegal, and France. **Conclusions** This analysis shows that many of the most powerful factors associated with physician migration are difficult or impossible for countries to change through public policy. GDP per capita and proximity to the U.S. are two of the most powerful predictors of physician migration. Networks of immigrants in the U.S. and fewer political and civil liberties also put countries at higher risk for physician emigration. Several other factors that were associated with physician migration might be more easily amenable to policy intervention. These factors include the absence of a medical school and medical instruction in English. Policies addressing these factors would involve making several difficult tradeoffs, however. Other examples of policies that are effective in minimizing physician migration might be found by examining countries with lower-than-expected migration rates.

Koritsas S, et al. Prevalence and predictors of occupational violence and aggression towards GPs: a cross-sectional study. *British Journal of General Practice* 2007 57 (545) 967-70. DOI: 10.3399/096016407782604848

Occupational violence and aggression are common in general practice. This study examined occupational violence and aggression against GPs in terms of prevalence and predictive factors, such as sex of GP, and practice location. Over half of the GPs sampled had experienced at least one form of violence and aggression; more female than male GPs experienced sexual harassment; and there was no difference in the number of metropolitan and rural GPs who had experienced violence and aggression. Predictors emerged for verbal abuse, intimidation, physical abuse, and sexual harassment.

Larson E H, Hart L G. Growth and change in the physician assistant workforce in the United States, 1967-2000. *Journal of Allied Health* 2007 36 (3) 121-30.

The physician assistant (PA) profession grew rapidly in the 1970s and 1990s. As acceptance of PAs in the health care system increased, roles for PAs in specialty care took shape and the scope of PA practice became more clearly defined. This report describes key elements of change in the demography and distribution of the PA population between 1967 and 2000, as well as the spread of PA training programs. Individual-level data from the American Academy of Physician Assistants, supplemented with county-level aggregate data from the Area Resource File, were used to describe the emergence of the PA profession between 1967 and 2000. Data on 49,641 PAs who had completed training by 2000 were analyzed. More than half (52.4%) of PAs active in 2000 were women. PA participation in the rural workforce remains high, with more than 18% of PAs practicing in rural settings, compared with about 20% in 1980. Primary care participation appears to have stabilized at about 47% among active PAs for whom specialty is known. By 2000, 51.5% of practicing PAs had been trained in the states where they worked. The profession has grown rapidly; 56% of all PAs were trained between 1991 and 2000. In 2000, more than 42% of accredited PA programs offered a master's degree, compared to master's degree programs in 1986. Although many critical issues of scope of practice and patient and physician acceptance of PAs have been resolved, the PA profession remains young and continues to evolve. Whether the historical contribution of PAs to primary care for rural and underserved populations can be sustained in the face of increasing specialization and higher-level academic credentialing is not clear.

Sargent P, et al. Patient and carer perceptions of case management for long-term conditions. *Health and Social Care in the Community* 2007 15 (6) 511-9 DOI: 10.1111/j.1365-2524.2007.00708.x

- : Nurse-led case management programmes have become increasingly popular over the last 15 years. Countries such as the USA, Canada, Sweden and the Netherlands have long running case management programmes in place for frail elderly people. The Department of Health in England has recently introduced a 'community matron' role to provide case management to patients with highly complex long-term conditions; a group that is predominantly comprised of elderly people. Department of Health policy documents do not define the day-to-day role of community matrons but instead describe the objectives and principles of case management for long-term conditions. The aim of this qualitative study was to describe case management from the perspective of patients and carers in

order to develop a clearer understanding of how the model is being delivered for patients with long-term conditions. In-depth interviews were conducted with a purposive sample of 72 patients and 52 carers who had experience of case management. Five categories of case management tasks emerged from the data: clinical care, co-ordination of care, education, advocacy and psychosocial support. Psychosocial support was emphasised by both patients and carers, and was viewed as equally important to clinical care. Patient and carer perceptions of case management appear to contrast with descriptions contained in Department of Health guidance, suggesting an 'implementation surplus' in relation to the policy. This particularly appears to be the case for psychosocial support activities, which are not described in official policy documents. The provision of significant psychosocial support by community matrons also appears to differentiate the model from most other case management programmes for frail elderly people described in the literature. The findings emphasise the importance of seeking patient and carer input when designing new case management programmes.

Starfield B, Fryer GE, Jr. The primary care physician workforce: ethical and policy implications. *Annals of Family Medicine* 2007 5 (6) 486-91. DOI: 10.1370/afm.720

Purpose: We undertook a study to examine the characteristics of countries exporting physicians to the United States according to their relative contribution to the primary care supply in the United States. **Methods:** We used data from the World Health Organization and from the American Medical Association Physician Masterfile to gather sociodemographic, health system, and health characteristics of countries and the number of international medical graduates (IMGs) for the countries, according to the specialty of their practice in the United States. **Results:** Countries whose medical school graduates added a relatively greater percentage of the primary care physicians than the overall percentage of primary care physicians in the United States (31%) were poor countries with relatively extreme physician shortages, high infant mortality rates, lower life expectancies, and lower immunization rates than countries contributing relatively more specialists to the US physician workforce. **Conclusion:** The United States disproportionately uses graduates of foreign medical schools from the poorest and most deprived countries to maintain its primary care physician supply. The ethical aspects of depending on foreign medical graduates is an important issue, especially when it deprives disadvantaged countries of their graduates to buttress a declining US primary care physician supply

Storey C, et al. Nurses working in primary and community care settings in England: problems and challenges in identifying numbers. *Journal of Nursing Management* 2007 15 (8) 847-52. DOI: 10.1111/j.1365-2934.2007.00746.x

Background One third of the primary care nursing workforce is aged 50 years and over. Workforce planning is essential if primary care is to ensure that there are appropriate numbers of nurses available to replace the loss of experienced nurses as they approach retirement. **Introduction** As part of an ongoing study to explore the factors influencing retention of female nurses over the age of 50 years in the primary care nursing workforce, a questionnaire survey targeting all community nurses employed in five Primary Care

Trusts was undertaken. Accurate statistics on the number and type of community nurse employed in the five Primary Care Trusts were sought to: (i) identify a denominator to accurately identify the response rates to questionnaires in the survey of Primary Care Trusts; and (ii) to compare the Primary Care Trust data with Department of Health statistics to investigate the accuracy of workforce data. A number of problems with locating accurate primary care nursing workforce statistics were identified. Aim The purpose of this paper is to highlight the difficulties inherent in collating workforce data and the implications for future workforce planning, both locally and nationally. The impact on research is also highlighted. •An ageing nursing workforce indicates that primary care nursing will experience significant reductions in its workforce •Local and National workforce statistics for primary care are flawed .•There are significant gaps in primary care data for school and practice nurses. •There needs to be clarification and a consensus for the term 'community nurse'. •The expansion of the public health role for school nurses is seriously challenged because of limited availability of appropriately qualified nurses and an urgent need for an investigation into school nursing statistics .•Future workforce planning and development needs to be based on accurate and reliable statistics, to plan for an ageing nursing workforce .•The quality of research in primary care is compromised because of the lack of availability of accurate nursing workforce data. Conclusions Effective delivery of the NHS Plan requires a thorough understanding of the composition of the primary care nursing workforce and targets need to be based on accurate and reliable workforce statistics.

Ulrich C, et al. Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Social Science and Medicine* 2007 65 (8) 1708-19 DOI: 10.1016/j.socscimed.2007.05.050

Nurses and social workers are fundamental to the delivery of quality health care across the continuum of care. As health care becomes increasingly complex, these providers encounter difficult ethical issues in patient care, perceive limited respect in their work, and are increasingly dissatisfied. However, the link between ethics-related work factors and job satisfaction and intent-to-leave one's job has rarely been considered. In this paper, we describe how nurses and social workers in the US view the ethical climate in which they work, including the degree of ethics stress they feel, and the adequacy of organizational resources to address their ethical concerns. Controlling for socio-demographics, we examined the extent to which these factors affect nurses and social workers' job satisfaction and their interest in leaving their current position. Data were from self-administered mail questionnaires of 1215 randomly selected nurses and social workers in four census regions of the US. Respondents reported feeling powerless (32.5%) and overwhelmed (34.7%) with ethical issues in the workplace and frustration (52.8%) and fatigue (40%) when they cannot resolve ethical issues. In multivariate models, a positive ethical climate and job satisfaction protected against respondents' intentions to leave as did perceptions of adequate or extensive institutional support for dealing with ethical issues. Black nurses were 3.21 times more likely than white nurses to want to leave their position. We suggest several strategies to reduce ethics stress and improve the ethical climate of the workplace for nurses and social workers.

Wakeling J, McGregor J R, Bagnall G. Stop the brain drain: ways to improve recruitment and retention to Scottish consultant posts. *Scottish Medical Journal* 2007 52 (2) 10-13.

Background and aims: NHS Scotland loses approximately one-third of Specialist Registrars (SpRs) it trains to consultant posts elsewhere. This has considerable resource and service implications and is the cause of intense political frustration. This study sought to gather data about the career intentions of SpRs and to discover what factors influence their career decisions. Methods: All SpRs in Scotland due to gain their Certificate of Completion of Specialist Training (CCST) between April 2005 and March 2006 were approached to take part in an interview about their career aspirations. Interviews, using a structured interview schedule, took place in spring 2005. Results: 198 SpRs were interviewed--75% of the target population. Almost three-quarters would prefer to stay in Scotland if possible, but when asked to realistically predict where they would take up a consultant post, this proportion had dropped to 64%. Perceived barriers to working in Scotland included the large number of District General Hospital (DGH) posts (often with onerous on-call rotas). A further problem concerned poor information flow between NHS Boards and trainees, with trainees being lost to Scotland who might have stayed if a job had been advertised in time. Conclusions: The majority of SpRs would prefer to stay in Scotland for their consultant career. There is a need to improve information flow between NHS Boards and trainees. NHS Boards need to know more about the career intentions of trainees and training committees and trainees need to be informed as to when and where posts will be advertised. Posts in DGHs might be made more appealing by having some sessions in larger teaching hospitals (although split-site working is not always popular). Flexibility and part-time options need to be promoted.