VIEWS

EDITORIAL

A year of living dangerously

How much more can general practice take? As we enter what looks set to be an acutely difficult year, that's the unspoken question GPs are asking as they batten down the hatches. A revamped contract, a mountain of QOF work, commissioning, revalidation, rationing and more; 2013 is shaping up to be the perfect storm.

A squeeze on practice funding is nothing new of course. But in England and Wales at least, the looming contract imposition – an imposition the GPC now admits it has no prospect of stopping – feels like a game-changer.

For the first time, practices are openly discussing what QOF work they will no longer be able to afford to do. For many, the four new DESs don't look worth the effort. And with accountants predicting a sharp drop in overall practice funding, patient care will undoubtedly suffer.

There is no doubt GP partners will, as ever, bear the brunt. But this time even a 5% or 10% reduction in take-home pay may not be enough. GPs are talking of cutting chronic disease management work and minor surgery, and relying more on nurses and healthcare assistants to triage patients. It seems inevitable, as LMCs are warning, that 'some patients will slip through the net'.

For many GPs then it will be a year of living dangerously, of anxious number crunching and tough decisions. But ministers, flushed with the success of outmanoeuvring the BMA, must take the longer view.

It now seems unlikely the contract changes will meet with any formal opposition. Industrial action is just not viable, and – despite support from a majority of GPs polled by Pulse – the GPC has also ruled out any kind of commissioning boycott.

But the fact remains that the Government is forcing through potentially devastating changes at exactly the moment when it is heavily reliant on GPs to lead its commissioning revolution. And even without any kind of formal protest, the impact on the NHS reforms may be severe. Practices will not officially withdraw from CCGs, but some will necessarily turn in on themselves. Many rank-and-file, apolitical GPs who might have shown a cautious interest in commissioning will now have neither the time nor the inclination to get involved.

> Even without any formal opposition, the impact on the NHS reforms may be severe

Ultimately, as GPC chair Dr Laurence Buckman says in our Big Interview this month, the Government holds all the cards. But, with one eye on the bigger picture, health secretary Jeremy Hunt should listen to GPs' concerns and offer meaningful concessions, even if he doesn't have to. Otherwise goodwill from GPs at a critical juncture for the NHS will be in very short supply indeed.

The new-look Pulse

This is the first issue of our new-look monthly magazine, and we hope you like what you've seen so far. But we can now include in print only a small fraction of our news, analysis, business advice and clinical education. So if you're a regular reader and you're not already signed up, please go to pulsetoday.co.uk/emails to make sure you receive the best of our content on a daily basis. Please do let me know what you think of the magazine's redesign at editor@pulsetoday.co.uk.

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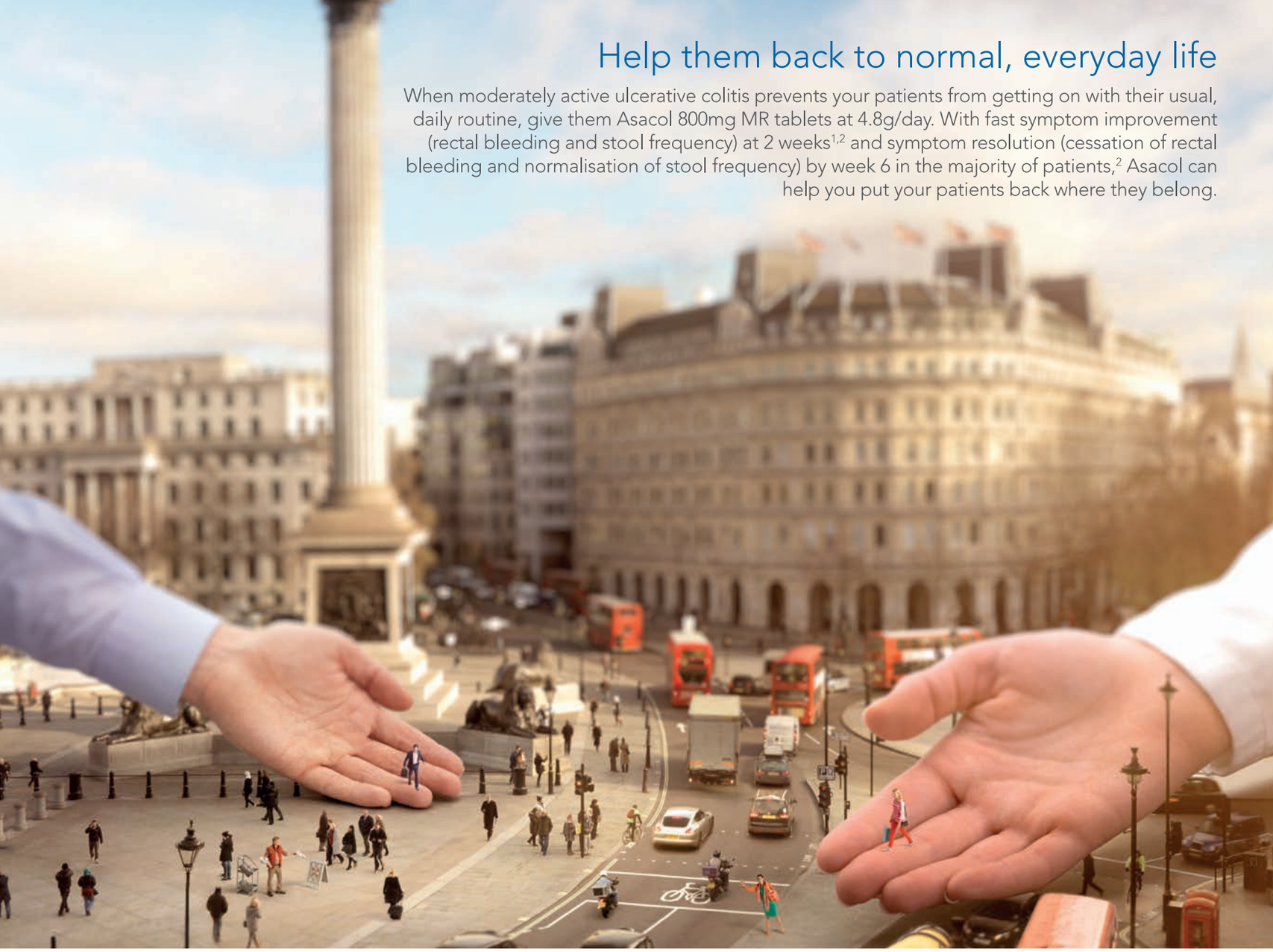

Combined Abbreviated Prescribing Information: **Asacol 400mg MR Tablet, Asacol 800mg MR Tablet, Asacol 250mg and 500mg Suppositories and Asacol Foam Enema** ***Presentation:*** **Asacol 400mg MR Tablets**, PL 10947/0011; each modified release tablet contains 400mg mesalazine (5-aminosalicylic acid). Bottles of 120, £39.21. Bottles of 90, £29.41. **Asacol 800mg MR Tablets**, PL 10947/0012; each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Bottles of 180, £117.62. **Asacol 250mg Suppositories**, PL 10947/0013, each containing 250mg mesalazine. Packs of 20, £4.82. **Asacol 500mg Suppositories**, PL 10947/0014, each containing 500mg mesalazine. Packs of 10, £4.82. **Asacol Foam Enema**, PL 10947/0015, 1g mesalazine per metered dose. Carton containing can of 14 metered doses, 14 disposable applicators and 14 disposable plastic bags, £26.72 ***Indications:*** Ulcerative colitis: Treatment of mild to moderate acute exacerbations. Maintenance of remission. Suppositories particularly appropriate for distal disease, Foam Enema for distal colon disease only. **400mg Tablets, 800mg Tablets, Suppositories**: Maintenance of remission. **400mg Tablets and 800mg Tablets only:** Crohn's ileo-colitis: Maintenance of remission. ***Dosage and administration:*** **ADULTS: 400mg Tablets:** Acute disease: 6 tablets a day, in divided doses, with concomitant corticosteroid therapy where clinically indicated. Maintenance therapy: 3 to 6 tablets a day, in divided doses. **800mg Tablets:** Mild acute exacerbations: 3 tablets a day in divided doses. Moderate acute exacerbations: 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Suppositories:** *250mg:* 3 to 6 a day, in divided doses, with the last dose at bedtime. *500mg:* A maximum of 3 a day, in divided doses, with the last dose at bedtime. **Foam Enema:** 1 (disease of rectosigmoid region) or 2 (disease of descending colon) metered doses as single daily dose for 4-6 weeks. **ELDERLY:** The normal adult dosage may be used unless renal function is impaired. **CHILDREN: 800mg Tablets:** Not recommended. **400mg Tablets, Suppositories, Foam Enema:** No dosage recommendation. ***Contra-indications:*** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR <20ml/min). **400mg Tablets, Suppositories and Foam Enema only:** Children under 2 years of age. **800mg Tablets only:** Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer, haemorrhagic tendency. ***Precautions:*** Use in the elderly should be cautious and subject to patients having a normal renal function. Asacol should be used with extreme caution in patients with confirmed mild to moderate renal impairment. Renal function should be monitored (with serum creatinine levels measured) prior to start of treatment, and periodically during treatment, taking into account individual history & risk factors. Mesalazine should be discontinued if renal function deteriorates. If dehydration develops, normal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some with fatal outcome) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation, during therapy, and are required immediately if the patient develops unexplained bleeding, bruising, purpura, anaemia, fever or sore throat. Stop treatment if suspicion or evidence of blood dyscrasia. Concurrent use of other known nephrotoxic agents, e.g. NSAIDs & azathioprine, may increase risk of renal reactions. **400mg Tablets and 800mg Tablets:** Lactulose or similar preparations which lower stool pH should not be concomitantly administered. **400mg tablets, Suppositories, Foam Enema:** Only use during pregnancy if benefits outweigh the risk. Avoid during lactation unless essential. **800mg Tablets only:** Mesalazine should be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonate develops suspected adverse reactions consideration should be given to discontinuation of breast-feeding or discontinuation of treatment of the mother. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting, abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because of the presence of lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. ***Undesirable Effects:*** **Common:** Nausea, diarrhoea, abdominal pain, headache. Rare reports of leucopenia, neutropenia, agranulocytosis, aplastic anaemia, thrombocytopenia, peripheral neuropathy, pancreatitis, abnormalities of hepatic function and hepatitis, myocarditis, pericarditis, alopecia, lupus erythematosus-like reactions and rash (inc. urticaria), drug fever, interstitial nephritis and nephrotic syndrome with oral mesalazine treatment, usually reversible on withdrawal. Renal failure has been reported. Suspect nephrotoxicity in patients developing renal dysfunction. Very rarely, mesalazine may be associated with exacerbation of the symptoms of colitis, Stevens Johnson syndrome & erythema multiforme. **400mg Tablets, Suppositories, Foam Enema:** Rare reports of allergic and fibrotic lung reactions. **800mg Tablets only:** Common: vomiting, arthralgia / myalgia. Rare reports of vertigo, bronchospasm, eosinophilic pneumonia, bullous skin reactions. Very rarely, interstitial pneumonitis. **Suppositories, Foam Enema:** Rarely, local irritation may occur after use of rectal dosage forms of mesalazine. ***Legal category:*** POM. ***Marketing Authorisation Holder:*** Warner Chilcott UK Ltd, Old Belfast Road, Millbrook, Larne, County Antrim, BT40 2SH, UK. Asacol is a trademark. Refer to Summary of Product Characteristics before prescribing. Date of preparation Feb 2012. AS8478a.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Warner Chilcott UK Ltd on 0800 0328701

References:

1. Orchard T *et al. Aliment Pharmacol Ther* 2011; **33**(9): 1028–1035.

2. Data on file: UK/AS/0125/08-11b(1).

Date of preparation: December 2012

UK/AS/0175/12-12b

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FEEDBACK

Letter of the month

RCGP must recognise CSA problems as more than just 'noise'

From Dr Aninda Banerjea, Dr Keith Birrell, Dr Anne Blandford, Dr Neil Brownlee, Dr Richard Croft, Dr Raj Dussad, Dr Eamonn Kennan, Dr Nageswarao Kolla, Dr Nasir Nabi, Dr Uma Narayanan, Dr Vidya Parajulie, Dr Geoffrey Potter, Dr Selvarajan Rajarajan, Dr Anand Rischie, Dr Nitish Sahoo, Dr Sangeeta Shah and Dr Kamal Sidhu. All signatories are GP trainers except Dr Potter, who is a former trainer

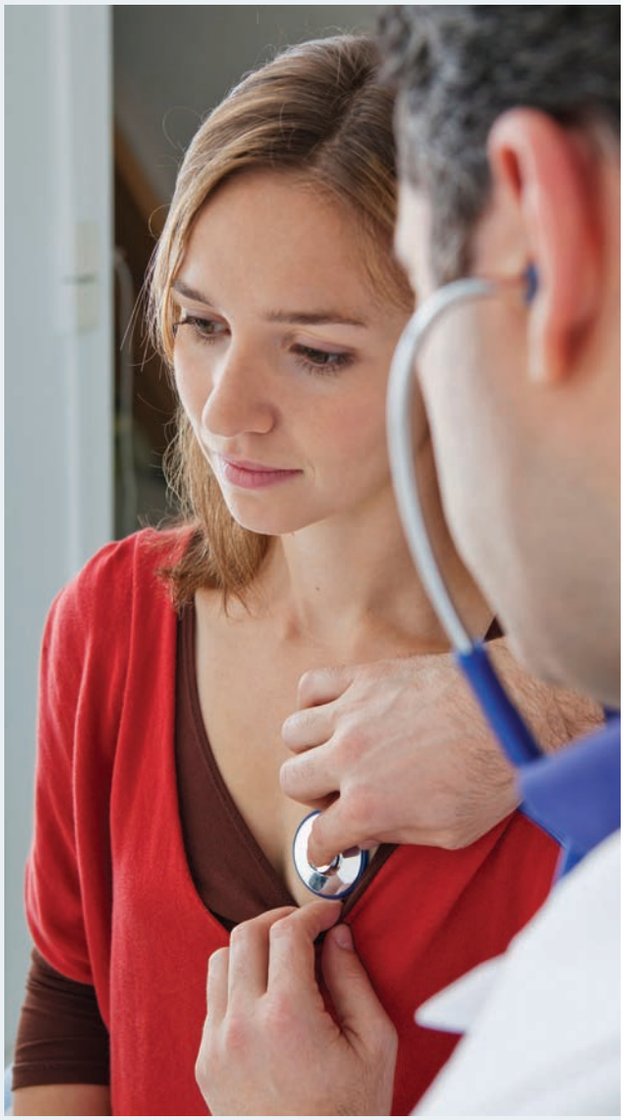
General practice is the only specialty where failing the exit examination means the trainees have no choice but to quit general practice ('RCGP study finds CSA exam is fair', pulsetoday.co.uk/news). This fact sets the RCGP apart from other medical colleges and faculties.

International medical graduates (IMGs) have historically always formed a significant proportion of the GP workforce in the UK and the clear disparity between their CSA pass rate and that of UK-trained doctors neither existed in the old MRCGP, nor is heard of in any comparable international examination.

There has been anecdotal evidence that trainees deemed competent by their trainers – considered to be the best predictors of trainees least likely to struggle – are ending up failing the examinations multiple times. This is a disservice not only to the trainees and their families but to our patients, the general public and the taxpayer at large.

It is disappointing that the widely respected RCGP chair, Professor Clare Gerada, has termed the controversy 'noise'. All the stakeholders need to do a root cause analysis and debate the reasons and potential solutions – whether this involves revamping the examinations, regionalising them, changing the way feedback is given, video recording the examination, offering an alternative route to qualification and/or extra trainee/trainer support, additional training (and attempts) for candidates likely to fail, or reviewing the GP training selection process.

If IMGs do perform poorly and the examinations are unbiased, why do the RCGP and deaneries allow patients to be exposed to practising doctors whom they statistically expect to fail exit exams? The selection process for GP training must be reviewed, as it is this that deems them competent to be trained and then, during their latter years of training, concludes that they are unfit to be GPs.



Should the CSA exam be revamped?

> The RCGP holds a monopoly position, so has a moral obligation to address concerns raised

It was reported in the media after a meeting of the British Association of Physicians of Indian Origin (BAPIO) with the RCGP that the number of attempts at the AKT and CSA may be increased to six.

While this would reduce the pressure on candidates, a long-term solution is required. RCGP statistics show that increasing the number of attempts does not result in a significant improvement in pass rates. The financial impact of repeated exams (the CSA costs more than £1,500 per attempt) cannot be overstated at that stage of a trainee's career.

The RCGP holds a monopoly position, so has a moral obligation to address concerns raised, irrespective of the source and reasons.

We take this opportunity to kindly request the college reviews the nMRCGP examinations with urgency.

The GMC should take over the CSA

From Dr Umesh Prabhu, vice chair, British International Doctors' Association and consultant paediatrician in Lancashire, via pulsetoday.co.uk

The defensive attitude of the college saddens me, but what really upsets me is its attitude towards CSA exam results. Unless the college accepts there may be an issue, it won't change. No exam can be fair where UK-trained black and minority ethnic doctors' chance of failure is six times greater than that of UK-trained white trainees.

It's time for the GMC to take over or remove the exit exam altogether and come up with a fairer exam that benefits patients, the NHS and the country – and not the college or its members.

Charging the worried-well is the way forward

From Dr Bryan Anglim, Ipswich, via pulsetoday.co.uk

I think charging patients for care if they lead an unhealthy lifestyle misses the biggest point ('Why charging for care is not the answer', pulsetoday.co.uk/ramscar). The group 'wasting' the most money are those anxious about their health: who ask a GP to check their chest when they have a cold or take their child's bruises to A&E. Many of these cases would not bother if there was a small charge and very few would do so if they paid the true cost of the attendance. Is anyone brave enough to tackle this?

Don't dump GPs with the obesity epidemic

From Dr Tim Binmore, Newcastle, via pulsetoday.co.uk

Dr Matt Capehorn writes that 'over time, having more weight-management programmes across the country will add to the existing evidence base and allow us to see what works best for patients' ('We must go beyond the "fat register" in the QOF', pulsetoday.co.uk/opinion).

GPs are being asked to tackle the

ALAMY

'obesity epidemic' by doing more but, in all the articles that I see by enthusiasts, most of the argument is taken up by the problem, and little by what primary care can do effectively. There isn't yet the evidence to support these interventions and so we need to avoid taking responsibility for the problem while the Government pussyfoots around food companies, fast food and school meals.

Practices in deprived areas work harder

From Dr Binoy Kumar, Preston, via pulsetoday.co.uk
Practices in deprived areas have to work twice as hard as others ('GPC votes to open talks with DH on funding boost for practices in deprived areas', pulsetoday.co.uk/news). They should be rewarded handsomely. I am surprised the GPC and DH have not recognised this until now.

Elderly boom needs innovative thinking

From Dr John Havard, Saxmundham, Suffolk
Our only chance of weathering the demographic tsunami of our elderly population is for family, friends and neighbours to help them to remain independent.

In east Suffolk, we are part of a scheme to provide 'easy Skype' to elderly isolated patients via their TV sets, using technology to complement personal contact. Many look forward to a quick audiovisual chat about their welfare after *Coronation Street*, but patients also use the system to talk to their families – the relative only needs a smartphone. We are also training 72-hour live-in carers at every practice to prevent urgent social

ONLINE

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and soft medical admissions. This month we will start using these practice-based carers to get patients home from hospital sooner to head off the dependency slide.

The public needs to play an increasing role and many more simple ideas like these need to go to market.

Give the GPC credit where it's due

From Dr Peter Swinyard, chair, Family Doctor Association, via pulsetoday.co.uk
If the GPC is past its sell-by date, with what would you replace it ('Majority of GPs back commissioning boycott as "outmanoeuvred" GPC blamed in contract row', pulsetoday.co.uk/news)? The committee will act as our sole negotiating body in England, where we have a single authority holding our contracts (from April). We underestimate the GPC's negotiators and what they do behind the scenes to prevent all sorts of foulness and calumny being visited upon us. I am always interested in a fair debate on our representation, but blaming the messenger for the message is not helpful.

A union by any other name

From Dr John Glasspool, Southampton
Cowardly, bloodless, caitiff, chicken, cowed, craven, droopy, effete, etiolated, fainthearted, feeble, flabby, flaccid, floppy, funking, goosy, gutless, henhearted, impotent, invertebrate, lily-livered, marrowless, milk-livered, milksoppish, mousy, overtimorous, panic-prone, pigeonhearted, pithless, pliable, poltroonish, pusillanimous, rabbity, recreant, rubbery, sapless, shaky, shivery, shrinking, sinewless, skittery, startlish, strengthless, timorous, tremulous, trepidant, unhardened, unstrung, weak-kneed, weak-willed, weakhearted, white-livered, worthless, yellow, British Medical Association.

What you're saying online

'I don't see any problem with the suggestion that pharmacists fit IUDs. Anyway, must dash, just off to see my dentist for a colonoscopy.'

'I am all for the Tesco model. I would love to display a sign in my consulting room that says "express checkout, two items or less".'

'How about a Friends and Family test for MPs? No, thought not...'

Read what your GP colleagues are saying at pulsetoday.co.uk/your-comments

THE BIG INTERVIEW

Dr Laurence Buckman

‘Ultimately, the Government holds all the cards’

Can the GPC do anything to stop ministers imposing the most wide-ranging changes to practice funding in the history of the new GP contract? GPC chair Dr Laurence Buckman tells Sofia Lind why it’s going to be very difficult

‘We had reached an agreement with a part of the Government, which another part of the Government didn’t want, and matters came to a sudden stop,’ says Dr Laurence Buckman.

In his distinctive way of speaking – short, clipped sentences, matter of fact and to the point – the north London GP and GPC chair is attempting to explain why this year’s contract talks broke down in such catastrophic fashion.

In October, apparently out of the blue, the Department of Health announced five months of negotiations had collapsed and said it intended instead to unilaterally impose a raft of contractual changes – changes that will have a significant impact on the workload and pay of every GP from April.

It’s not the first time Dr Buckman has faced an imposition. In his first year as GPC chair, back in 2008, Gordon Brown’s Labour government railroaded through extended hours. So he speaks from bitter experience when he warns practices they should prepare for the worst.

‘You can’t block what governments decide to do,’ he says simply. ‘There are many things governments decide to do that I don’t agree with, or indeed that the vast majority of the population doesn’t agree with. But that doesn’t mean they don’t happen.’

If he sounds somewhat defensive, it’s with good reason. A Pulse snapshot survey over Christmas suggested many GPs believe the GPC is at least partially to blame, with half claiming negotiators did a ‘poor’ or ‘very poor’ job of representing the profession.

Dr Buckman doesn’t believe the survey is large enough to be representative, but accepts some degree of criticism is ‘inevitable’.

‘I don’t think we did a bad job, but we did our job and if they’re disappointed, well, I agree with them,’ he says. ‘But actually, ultimately the Government holds all the cards. If the Government decides that anything will be the case, then that’s how it will be.’

The GPC will survey the profession and hold a series of roadshows around the country this month – ‘the whole point is being seen, you don’t hide behind an email’, he says. But with formal consultation on the proposed changes now well under way, Dr Buckman’s focus is very much on minimising the fallout from what fellow negotiator Dr Chaand Nagpaul has called ‘the most significant quantum reduction in the GP contract that we’ve ever seen’.

‘Now what we have to do is make sure that GPs are as equipped as they can be to cope with what is coming, that we can do our best to diminish the damage that the deal, as imposed, will put on doctors,’ he says.

The uncomfortable truth is the contract imposition was announced – perhaps not entirely coincidentally – when the BMA was still reeling from the failure of its industrial action on pensions.

EXTRA ONLINE

The full interview
Watch the full interview or selected highlights and read the full transcript
pulsetoday.co.uk/tbi-buckman

CV

- Single-handed GP in Finchley, north London
- GPC chair since 2007
- Member of BMA Council and a GPC negotiator since 1997
- Special interests include psychotherapy and neurology

PAUL STUART

THE BIG INTERVIEW

Dr Buckman on...

... criticism of the GPC
'I don't think we did a bad job, but if [GPs] are disappointed, well, I agree with them'

... why he won't lead a commissioning boycott
'The majority of GPs don't care much about commissioning, but those who do are unlikely to stop because the BMA tells them to'

... being revalidated
'It was OK. It was the same as an appraisal. You just have to grit your teeth and cope with it'

... the pension reforms
'People 10 years younger than me will suffer. And those 20 years younger will question why they are becoming GPs'

Dr Buckman brushes aside any suggestion that just one GP in 10 supporting the 'Day of Action' last June weakened his hand in contract talks – 'I don't think it made the slightest difference, it was about an unrelated matter' – but he is clear there will be no repeat.

'There is no point in calling for industrial action when nobody takes it,' he says.

He also rules out a boycott of commissioning, despite support from a number of senior figures within the BMA and a slim majority of GPs polled by Pulse.

'Some of us suspect that the Government may not actually mind terribly much if GPs did not take part in commissioning, so we may be playing into their hand by saying: "Well then, we'll stomp off the pitch." Who would take over? It sure won't be GPs.'

Instead, the focus is on damage limitation – and he is clear that the damage will be substantial.

'A lot of English GPs will see significant adverse cash movements, and I don't have an answer to that except to say it is the same for me and it is not something I am pleased with,' he says.

The GPC estimates the removal of 150 QOF points will cost the average practice £31,000 a year – 'a member of staff, if you choose to do that' – and Dr Buckman believes GPs will struggle to tackle the four new DESs into which funding has been shifted.

'I am not sure actually you could take on all four DESs. The workload of all four is very steep.'

'Most' GPs will see a significant cut in their personal pay packet, he believes – as he expects to personally – and cuts to patient services are 'inevitable'. BMA economists are currently modelling the full impact of the changes, and the GPC will provide detailed guidance to practices.

'I think our main job will be to help people understand what this will do to their practice incomes, practice organisation, their staffing levels, their take-home pay. It is a lot to take in. These are major, disturbing changes that are going to upset people a lot.'

It's a difficult, thankless task, and so it's perhaps unsurprising Dr Buckman is not entirely sorry to be stepping down as GPC chair in the summer, after six years in the hot seat and 15 as a negotiator.

'Would I have liked to stay on and get us out of this? Not really. I'll be quite happy to let somebody else do it. This is too big a job for any individual to try and solve.

'I think some GPs have the naive idea that if I go and thump the table hard enough somebody will wake up and listen but it's not like that at all.'

And his legacy? He smiles mischievously.

'A world at peace is how I'd like to go out. At least an NHS at peace, but that won't happen. So I'll go out making a noise, like I always do.'

ONLINE

New this month
Go online to see Big Interviews with:
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- Dr Richard West, chair of the Dispensing Doctors' Association

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References: 1. SPIRIVA® 18 µg Summary of Product Characteristics. http://medicines.org.uk/emc. Accessed August 2012. **2.** Tashkin DP *et al.* for the UPLIFT Study Investigators. A 4-year trial of tiotropium in chronic obstructive pulmonary disease. *N Engl J Med* 2008;359:1543–1554.

Prescribing Information (UK) SPIRIVA® (tiotropium)
Inhalation powder, hard capsules containing 18 microgram tiotropium (as bromide monohydrate). **Indication:** Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). **Dose and Administration:** Adults only age 18 years or over: Inhalation of the contents of one capsule once daily from the HandiHaler® device. **Contraindications:** Hypersensitivity to tiotropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which contains milk protein. **Warnings and Precautions:** Not for the initial treatment of acute episodes of bronchospasm, i.e. rescue therapy. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation powder. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. In patients with moderate to severe renal impairment (creatinine clearance ≤ 50 ml/min) tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be cautioned to avoid getting the drug powder into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tiotropium bromide should not be used more frequently than once a day. Spiriva capsules contain 5.5 mg lactose monohydrate. **Interactions:** Although no formal drug interaction studies have been performed, tiotropium bromide inhalation powder has been used concomitantly with other drugs without clinical evidence of drug interactions. These include sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids, commonly used in the treatment of COPD. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. **Fertility, Pregnancy and Lactation:** No documented clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Tiotropium bromide should therefore only be used during pregnancy when clearly indicated. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of tiotropium bromide during breast feeding is not recommended. A decision on whether to continue or discontinue breast feeding or therapy with tiotropium bromide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotropium bromide therapy to the woman. Clinical data on fertility are not available for tiotropium. **Effects on ability to drive and use machines:** No studies have been performed. The occurrence of dizziness, blurred vision, or headache may influence the ability to drive and use machinery. **Undesirable effects:** Common (≥ 1/100 to <1/10) Dry mouth. Uncommon (≥ 1/1000 to <1/100) Dizziness, headache, taste disorders, vision blurred, atrial fibrillation, pharyngitis, dysphonia, cough, gastrooesophageal reflux disease, constipation, oropharyngeal candidiasis, rash, dysuria, urinary retention. Serious undesirable effects consistent with anticholinergic effects include glaucoma, constipation and intestinal obstruction including ileus paralytic as well as urinary retention. An increase in anticholinergic effects may occur with increasing age. Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** Combopack HandiHaler device and 30 capsules (3 blister strips) £34.87 Refill Pack 30 capsules (3 blister strips) £33.50. **Legal category:** POM. **MA Number:** PL 14598/0062. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. **Prepared in** August 2012.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

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OPINION

Intervention from on high has knocked my faith in commissioning

CCG chair Dr Helen Tattersfield used to see a future in clinical commissioning. But now, following a politically driven intervention, she is not so sure

In Lewisham, as in many CCGs all over the country, a group of experienced GPs have all given up hours of precious clinical and personal time, sacrificed the needs of their practices and attended seemingly endless meetings and training and assessment sessions in the name of clinical commissioning.

Why have we done this? For financial gain? Career status? Personal aggrandisement? Sometimes, perhaps, but in Lewisham it was because we saw an opportunity to make a difference. To get all the different players – primary and secondary care, community, council and voluntary sector – to work together, involve patients in their care and produce a local service where all parts had agreed aims and combined their resources, and where the tide of illness flowing into secondary care was diverted into effective health promotion and community-based care.

We had begun this work and were daily becoming more effective (and so we should have been, with the amount of money spent on our training). We were helped in this by a council and a local healthcare trust that shared our vision and were willing to put aside old ways of working to create something new.

We impressed those who came to test our readiness for authorisation, not just because we had the required documents but because our new collaboration had already had a significant impact on referrals, reduced unnecessary hospital admissions and spectacularly increased rates of childhood immunisation.

We were rightly proud of this; proud of our local trust, which had been key in the changes in secondary and community care required to bring this about, and inspired by the co-operative spirit of our local authority.

And then something happened to turn all that on its head.

Decisions about me, without me

South London Healthcare Trust (SLHT) is the most indebted in the country, losing in excess of £1 million a week through a combination of PFI contracts and service inefficiency. The trust was declared unsustainable and a trust special administrator (TSA) was appointed last July, likely to be the first of many such investigations into trust finances.

The TSA's solution controversially involves the dismantling of neighbouring Lewisham hospital – an efficient, locally responsive and financially healthy hospital. It will lose its acute care facilities and all dependent services, including maternity and paediatrics, to provide income to the failing trust and it will have its estate sold to reduce the trust's debt. Fearing the effects on our already deprived population's health, I wrote to health secretary Jeremy Hunt and suggested he stick to the principles of the Health and Social Care Act: allowing local commissioners to produce local solutions. I have yet to hear back from him.

Our patients were told they would get better care by travelling out of the borough (an expensive and stressful journey for many) to one of four admitting trusts.

The council is having to spread its already limited social care resources across trusts to safeguard the needs of Lewisham residents. But we as commissioners are expected to create new pathways of care and ensure a minimum number and length of hospital admissions with four providers to which our work is an insignificant fraction. Exercising any influence at all will require complex and time-consuming collaboration with five neighbouring CCGs.

> Our patients were told they would get better care by travelling out of the borough

We have very little influence too with our local population and GPs, who, with no trusted central provider, reject local pathways for the perceived 'quality care' at central London foundation trusts. Some even wonder if local commissioning will have any role at all.

Do I see a future in clinical commissioning? Obviously I used to. I and my fellow directors would not have committed so much to making this work if we did not. But now I am not so sure. Can we keep GPs engaged, having taken them on a journey of local co-operation to end up at a destination of external determination? It is hard to envisage this, just as it is hard to see GPs of the future committing their time and efforts to NHS initiatives.

So 'no decision about me, without me' becomes 'all decisions about me depend on the needs of others', where those 'others' are indebted trusts, failed institutions and specialists in ivory towers.

Meanwhile, local commissioners must return to the substitute bench, while the professional players get on with the match.

Dr Helen Tattersfield is the chair of Lewisham CCG and a GP in Bromley

More opinions online

NICE's 'one problem' solutions are no longer enough
Professor David Haslam, the new chair of NICE, on why he hopes his experience as a GP will make the institute's work more relevant to primary care
pulsetoday.co.uk/haslam

Why 2013 will be a defining year for GPs
Health secretary Jeremy Hunt (right) sets out his vision for the profession over the next 12 crucial months
pulsetoday.co.uk/health-sec

GPs aren't travel agents – and offering 'choice' wastes time
The time we spend talking patients through referral options could be better spent on patient care, writes GPC deputy chair Dr Richard Vautrey
pulsetoday.co.uk/vautrey

NHS ALLIANCE

McCARTNEY

Time to reclaim 'holistic' care

Prince Charles believes medicine should not be so 'literal' in its approach, but Margaret isn't convinced

Dr Margaret McCartney is a GP in Glasgow

Prince Charles' recent editorial in the *Journal of the Royal Society of Medicine*[1] is worth reading – because it explains how a little knowledge paired with unwavering beliefs can result in vastly mistaken conclusions.

Allow me to summarise: integrated health 'maximises the potential of conventional, lifestyle and complementary approaches in the process of healing'. HRH acknowledges he has been criticised for his belief that integrated healthcare is not just about 'repair of the (human) machine', but care of the 'mind, body and spirit'. To achieve this aim, he argues medicine should become 'less literal in its interpretation of patient needs and more inclusive in terms of what treatment may be required'. Symptoms may therefore be 'a metaphor for underlying disease and unhappiness'.

The upshot, he says, is that 'treatment may often be effective because of its symbolic meaning to the patient through effects that are now increasingly understood by the science of psychoneuroimmunology'. Big words!

The editorial then cites Marmot on stress and Blackburn on telomeres, expands on the need to have the 'human touch' and to hear the 'narrative' of the patient, and describes how his charities, working in Burnley, are making a difference because 'we know that alienated and uncaring communities adversely affect the health and wellbeing of those living in them'.

Let us examine the subliminal references to complementary therapies and the way in which pick-and-mix evidence selection can undermine what we know about health. HRH is right when he says that we should do more to 'enhance the length of contact and continuity' between doctors and patients – but if that time is spent doling out alternative medicine, we may as well not bother.

Where Prince Charles has it wrong, in my view, is in assuming that complementary therapies have a role in modern medicine. Relying on things we know don't work means we don't pay attention to what does work.

Sticking to alternative medicine because it is sometimes good at delivering placebo effects creates massive problems, not least in effectively misleading patients. Spending time with patients to talk, to understand, and to plan has positive effects, as too does continuity of care. My book, *The Patient Paradox*,[2] gathers evidence on how to generate caring effects without the use of alternative medicines or unethical placebos.

> "Advocates of alternatives think it's only them who 'care'

It we really want to look at the social determinants of health, we could start by believing the copious amount of work that tells us how bad inequalities are for health.

It's time for hard-nosed, evidence-based medicine to take back the word 'holistic'. For too long, the advocates of alternatives have allowed themselves to think that it is only them who really 'care'.

In fact, it is impossible to truly care for patients whom we think so little of that we give them placebos. This kind of thinking is endarkening. Our NHS deserves better.

ONLINE

Read more Dr McCartney columns at pulsetoday.co.uk/mccartney

References

1 HRH the Prince of Wales. 'Integrated health and post modern medicine'. *JR Soc Med* 2012, online 21 December. tinyurl.com/JRSM-HRH

2 McCartney M, *The Patient Paradox*. Pinter and Martin, 2012. thepatientparadox.com/references

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MA holder: Dermal Laboratories, Tatmore Place, Gosmore, Hitchin, Herts, SG4 7QR. **Date of preparation:** November 2012. 'Doublebase' and 'Dayleve' are trademarks.

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TOPICAL INNOVATION

COPPERFIELD

I've seen the future and it's all GPs' fault

Revalidation, CCG rationing and quality premium payments will give the national media even more GP-bashing sticks, predicts Copperfield

Dr Tony Copperfield is a GP in Essex

ONLINE

Read Copperfield's blog at pulsetoday.co.uk/copperfield or follow him on Twitter @DocCopperfield

There's just one problem with our small but perfectly formed new monthly organ. Because of the Christmas and New Year break intervening in deadlines, as I write this, you – the reader – are in the future. And I'm in the past.

It doesn't matter, though. Because I can guarantee that what I want to cathart about – reflex, belligerent, lazy, ill-informed media reports knocking us GPs – will still be topical. After all, they happen every week.

You'd think, by now, we'd be immune to being pilloried as feckless, workshy, overpaid sons and daughters of Satan. But, personally, I'm not. In particular, I remain enraged by those sanctimonious media stories about GPs who are 'too quick to prescribe'. And according to the finger-wagging hacks, our crimes are at their most heinous when we're fobbing the punters off with antibiotics, anti-obesity drugs and antidepressants.

Let's take those in order. Supposedly, we dish out ineffective antibiotics to viral patients just because we can't be fagged to discuss the merits of fluids and paracetamol – thereby risking ADRs, anaphylaxis and the proliferation of headline-grabbing superbugs.

Similarly, we skip earnest advice about diet and exercise in favour of forcing flabbies onto medication that adds faecal incontinence to their problem list and leaves our sewers steatorrhoeic.

Instead of encouraging our depressed patients to take a walk, have a chat and go online for some non-retail therapy, we ram a funnel down their throats and pour in SSRIs, screaming, 'Cheer up you miserable bastards.'

Except, as you and I know, that's not what happens. There's a simple reason why depressed/obese/fed-up-with-this-cold patients make appointments and it's definitely not to receive a homily about the benefits of smiling/smaller plates/menthol.

No. The fact is they've tried the self-help stuff already or they simply can't be arsed. They've come to us because they want a quick fix and we're the ones perceived as being able to prescribe it. It takes tenacity to book and attend appointments. If journalists truly believe that by the time patients have negotiated the system, they're arriving with a blank sheet of polite expectation rather than a bagful of sullen entitlement, then they're deluding themselves.

> "They've tried the self-help stuff already or they simply can't be arsed

Of course, we try to resist patients who act like FP10-homing devices but, sometimes, resistance is futile. Cue headline.

Clearly, things aren't going to get any better on the media front. This year, to go with the chronic barrage over our pay and perceived incompetence, and potshots aimed at our prescribing habits, the headline writers will have loads of new ammunition with which to annihilate our reputation: doctors failing revalidation or CQC registration, CCGs restricting services, GPs receiving commissioning premium payments and so on. We might as well run over the Andrex Puppy and have done with it.

It's an unwelcoming future. So, if it's OK with you I'll stay here, in the past.