Communicating with parents on the neonatal unit

Should we be doing more than just talking?

RESEARCH p28

Peter W Fowlie

consultant paediatrician
Neonatal Intensive Care Unit,
Ninewells Hospital and Medical
School, Dundee DD1 9SY
peter.fowlie@nhs.net

Allan Jackson

specialist registrar in neonatal
medicine
Neonatal Intensive Care Unit,
Ninewells Hospital and Medical
School, Dundee DD1 9SY

Competing interests:

None declared

BMJ 2007;334:1

doi: 10.1136/bmj.39063.441076.BE

Good communication underpins “good medical practice,”¹ whereas poor communication results in patient dissatisfaction, increased complaints, and increased litigation.² Surprisingly, therefore, other than in the field of cancer care³ there is a lack of literature to guide clinicians on how to improve communication. In this week’s *BMJ*, a randomised controlled trial by Koh and colleagues investigates whether providing mothers of babies in neonatal intensive care units with audiotapes of their conversations with a neonatologist improves recall of information and psychological wellbeing.⁴

The concept of family centred care within the neonatal unit is based on the philosophy that “[care] ... should be based on open and honest communication between parents and professionals.”⁵ Although few would disagree with this, many of the ethical and medical issues that are encountered routinely in the neonatal unit are highly complex and have to be communicated to parents who are under extreme pressure in a hostile environment.⁶ Effective communication is therefore a particular challenge in the neonatal unit.

The trial by Koh and colleagues found that mothers who received audiotapes of their consultation recalled significantly more information about diagnosis, treatment, and outcome than women in the control group at 10 days and at four months.

However, despite the encouraging results the trial has limitations. The primary outcome was recall of information up to four months, which is a relatively short follow-up period. Also, no significant differences were found for other outcomes such as patient satisfaction, parental anxiety and depression, or parental stress up to a year later. The interpretation and clinical importance attached to these findings may vary according to who is looking at the data—parent, neonatologist, neonatal nurse, family doctor, or healthcare provider.

Using audiotapes in clinical practice would raise important practical issues. Which conversations or discussions would be recorded and who would decide? Parents need to exchange information with medical and nursing staff,⁷ and it could be argued that using audiotapes might make the exchanges more formal.

Koh and colleagues used cassette tapes, which are becoming increasingly obsolete in today’s technologically advanced society. More recent formats like compact discs and MP3 files may be more appropri-

ate but are not yet universally used and need to be tested in this situation. Taped conversations may be regarded as part of the medical record, therefore a confidential archive would be required to store and retrieve the information. Data may need to be stored indefinitely for medicolegal reasons, which could be costly, although the use of electronic patient records might facilitate this. In developing countries where neonatal services have limited resources, introducing this sort of practice may not be seen as a priority.

Any communication strategy in whatever setting must be effective, practical, and affordable. While Koh and colleagues’ study adds to our knowledge and understanding of communication between doctors, patients, and relatives, the intervention needs to be made practical before it can be implemented widely. Other methods of improving communication such as providing written information, as already advocated by some professional bodies,⁸ may be more practical and are worthy of assessment.

- 1 UK General Medical Council. *Good medical practice*. London: GMC, 2006. www.gmc-uk.org/guidance/good_medical_practice/index.asp.
- 2 Teutsch C. Patient-doctor communication. *Med Clin North Am* 2003;87:1115-45.
- 3 Back A. Patient-physician communication in oncology: what does the evidence show? *Oncology Williston Park* 2006;20:67-74.
- 4 Koh THHG, Butow PN, Coory M, Budge D, Collie L-A, Whitehall J, et al. Provision of taped conversations with neonatologists to mothers of babies in intensive care: randomised controlled trial. *BMJ* 2006 doi:10.1136/bmj.39017.675648.BE.
- 5 Harrison H. The principles for family-centered neonatal care. *Pediatrics* 1993;92:643-50.
- 6 Walker CH. Neonatal intensive care and stress. *Arch Dis Child* 1982;57:85-8.
- 7 Kowalski WJ, Leef KH, Mackley A, Spear ML, Paul DA. Communicating with parents of premature infants: who is the informant? *J Perinatol* 2006;26:44-8.
- 8 Royal College of Paediatrics and Child Health. *Good medical practice in paediatrics and child health*. London: RCPCH, 2002. www.rcpch.ac.uk/publications/recent_publications/GMP.pdf.

Lower urinary tract symptoms in men

Self management is at least as effective as watchful waiting, and may delay further intervention

RESEARCH p25

Christopher R Chapple

professor of urology and consultant urological surgeon
Royal Hallamshire Hospital,
Sheffield S10 2JF
c.r.chapple@sheffield.ac.uk

Anand K Patel

urology research fellow
Royal Hallamshire Hospital, Sheffield
S10 2JF Research.

Competing interests:

CC has acted as a consultant for or received research funding from Pfizer, Astellas, Abbott, Allergan, and Recordati Pharmaceuticals.

BMJ 2007;334:2

doi: 10.1136/bmj.39063.645532.BE

Lower urinary tract symptoms—including voiding, storage, and postvoiding symptoms—occur in half of men over 65 and adversely affect quality of life and activities of daily living.^{1,2} Treatment varies from watchful waiting (active surveillance and monitoring) to medical and surgical management. While absolute indications for surgery exist—including persistent retention, severe symptoms, and secondary renal impairment—recent experience in clinical practice suggests that most patients do not need surgery in the long term and can be managed by conservative measures.³ In this week's *BMJ*, Brown and colleagues report the first randomised controlled trial on the effect of self management training as a first line treatment in men with lower urinary tract symptoms.⁴

Symptoms associated with bladder outlet obstruction due to histological benign prostatic hyperplasia vary in nature and severity. Currently, about a third of patients in the United Kingdom are managed with watchful waiting.⁵ Figures are probably similar internationally as this management strategy is recommended by several international urological associations and the UK National Institute for Health and Clinical Evidence. However, this form of management is not standardised. The type and timing of this monitoring varies, and it often consists of only an occasional review of symptoms. Professionals often provide variable amounts of advice, with specialist continence nurses providing the most.⁵

In recent years the patient-doctor relationship has altered. Patients increasingly wish to have a more proactive role and see themselves as consumers and not passive recipients of health care. Men often postpone seeing their doctor and try to manage their symptoms themselves initially.² Understandably, they often prefer to use conservative measures to control symptoms than take drugs long term or undergo surgical interventions that can have long term adverse effects, in particular on sexual function. Allowing patients to practise self management encourages them to take greater responsibility for their condition, its treatment, and its effect on their lives.⁶

The trial by Brown and colleagues shows that over a one year period 80% of men can be successfully managed by watchful waiting.⁴ These authors previously defined the components of self management using a research and development appropriateness method consensus process.⁷ The programme includes education tailored to the individual patient on the causes and natural course of lower urinary tract symptoms; reassurance regarding prostate cancer concerns; and advice regarding fluid management, toileting, and bladder retraining. Crucially, the programme helps promote behavioural change by

using techniques such as goal setting and problem solving, and by providing coping strategies for the patient in a structured manner through small group sessions.

Implementation of such a programme would be aided by training clinicians to acquire new skills, such as cognitive behavioural techniques.⁶ In other chronic conditions self management has been administered by lay people, who often have the same condition as the patient.⁸ Patients' needs will probably change over the course of their chronic condition, so their self management skills will need to be reassessed regularly.⁹

The results of the trial suggest that self management is effective for men with uncomplicated lower urinary tract symptoms. The size of the effect is twice as large as that of pharmacotherapy on symptoms compared with placebo in randomised trials.⁴

The trial does have limitations, however. The trial was a pragmatic one as bladder outlet obstruction was not assessed by measuring flow rate (although interestingly men with residual bladder volumes greater than 200 ml were excluded). A higher proportion of men had a university education in the self management group than in the control group (45% v 24%). Furthermore, selection of participants may have been biased as only men with sufficient time, interest, and motivation may choose to enter such a trial. Finally, men could not be blinded to their treatment.^{8,10}

The results should therefore be extrapolated to clinical practice with caution, at least until larger scale trials are completed. Nevertheless, in the meantime, alleviating symptoms and improving quality of life through self management will help patients and may reduce the financial burden on healthcare systems. The promotion of multidisciplinary team working between general practitioners, urologists, and continence nurses is an important step towards implementing self management strategies at a local level.

1 Garraway WM, Collins GN, Lee RJ. High prevalence of benign prostatic hypertrophy in the community. *Lancet* 1991;338: 469-71.

2 Scarpa RM. Lower urinary tract symptoms: what are the implications for the patients? *Eur Urol* 2001;40(suppl 4):12-20.

3 Thomas AW, Cannon A, Bartlett E, Ellis-Jones J, Abrams P. The natural history of lower urinary tract dysfunction in men: minimum 10-year urodynamic follow-up of untreated bladder outlet obstruction. *BJU Int* 2005;96:1301-6.

4 Brown CT, Yap T, Cromwell DA, Rixon L, Steed L, Mulligan K, et al. Self management for men with lower urinary tract symptoms: randomised controlled trial. *BMJ* 2006 doi: 10.1136/bmj.39010.551319.AE.

5 Brown CT, van der Meulen J, Mundy AR, Emberton M. Lifestyle and behavioural interventions for men on watchful waiting with uncomplicated lower urinary tract symptoms: a national multidisciplinary survey. *BJU Int* 2003;92:53-7.

6 Newman S, Steed L, Mulligan K. Self-management interventions for chronic illness. *Lancet* 2004;364:1523-37.

Extra references are on bmj.com

Case management for elderly people in the community

The Evercare model improves quality of care but does not reduce emergency admissions or mortality

RESEARCH p31

David A Black

consultant geriatrician
Queen Mary's Hospital, Sidcup, Kent
DA14 6LT
dblack@kssdeanery.ac.uk

Competing interests:
None declared.

BMJ 2007;334:3-4

doi: 10.1136/bmj.39027.550324.47

Reducing unplanned admissions to hospital is now a cornerstone of the commissioning plans of all primary care trusts as the national health service struggles with a rising tide of emergency admissions and a large financial deficit. The management and care of patients with long term conditions has become a priority; in particular, intervention to reduce the number of admissions of frail elderly patients with multiple chronic diseases. In this week's *BMJ*, Roland and colleagues report the impact of the Evercare approach to case management for elderly people living in the UK.¹

In 2002 the Department of Health started to fund innovative projects aimed at transforming chronic care and improving care for people with long term conditions, to reduce emergency admissions and, presumably, costs. The decision to pilot the Evercare model in 10 primary care trusts (PCTs) was based in part on a study from the United States which used nurse practitioners in a managed care programme that was directed specifically at long stay nursing home residents.² It found the incidence of admission to hospital was twice as high in control residents compared with Evercare residents over 15 months, with a similar pattern for preventable admissions. The study estimated that using a nurse practitioner saved \$103 000 (£54 000; €81 000) a year in hospital costs per nurse practitioner. Supporting this information were data from an Evercare project in Castlefields in the UK that had not been subjected to peer review. The Department of Health was so certain that the project would be successful that it decided to create 3000 posts for community matrons across the NHS by 2008 to fill a role similar to the advanced nurse practitioner on the Evercare scheme.

The UK's Evercare programme combines elements of nurse led assessment and intensive case management, but in the community and not in a nursing home setting. It includes data analysis to identify high risk patients and changes in jobs, in particular to the new role of advanced practice nurse with extended generalised skills, and changing processes to organise care around the patient's needs rather than the current organisational boundaries.³ In the UK Evercare study the largest group of high risk patients was those with two or more emergency admissions in the previous year.³

Despite these advances, the current evidence base for intervention to improve chronic care is still weak. A review of 560 studies found a complex picture with some evidence that initiatives could enhance satisfaction with care, quality of life, and in some cases the use of health services. Evidence to support case management is sparse, and there is even less information on new models of commissioning services or on whether

international programmes can be replicated in the UK.⁴ The Evercare model was particularly predicated on case management, which has been defined as "the process of planning, co-ordinating, managing and reviewing the care of an individual."^{5 6} A recent review of case management by the King's Fund found weak evidence for case management in preventing admissions to acute care and no consistent effect on the use of emergency departments.⁶

In early 2005 an interim assessment of the Evercare programme in 2003-4 reported that its benefits were mostly in terms of quality of care.³ Half the patients and carers felt that quality of care had improved, with a quarter believing that care was "a lot" better. Among carers, 95% had seen an improvement in the patient's ability to cope. Patients felt that they were highly involved in decisions about their care and treatment. Among general practitioners, 80% said the role of advanced nurse practitioner helped in delivering more holistic patient centred care.

The interim report came to no conclusions on hospital admissions. The major criterion for entry to the programme had been a history of two or more emergency admissions in the previous year. Yet an analysis of hospital episode statistics for people aged 65 or over with a history of emergency admissions in England showed that, although those with two or more such admissions constituted 38% of admissions in the index year, they accounted for fewer than 10% of admissions in the following year and just over 3% five years later.⁷ The reasons for this are complex, but probably include deaths, planned admissions to long term care, further planned admissions (for example, for respite care), and "regression towards the mean" in surviving patients.^{3 7 8}

This publication led to criticism about the failure to fund a properly controlled study beforehand; the cost and use of public funds (over £4m), with much of that going on travel, consultancy fees and training; and further national investment in a systematic case management approach across England without convincing evidence.^{9 10} Different outcomes might have been achieved if the project had hired its own nurses, and the maximum benefits might become apparent only in the second or third year.^{11 12}

The study that was subsequently commissioned used a complex design to overcome the lack of a straightforward control group and compared various outcomes in the 62 Evercare practices with between 6960 and 7695 control practices across England.¹ It found no effects on emergency admissions, emergency bed days, or mortality. Frustratingly, this adds little to help primary care trusts decide where to focus their commissioning efforts. The interim evidence of improved quality of care is welcomed by everyone

who works with older people; on the other hand, the study does not support using nurse practitioners to reduce hospital admissions in patients who have had previous emergency admissions.

Identifying patients at risk and intervening before or during the first or second admission may still be an effective model of case management, but we need to research better predictors to judge which patients require intervention. From the point of view of a frail older person admitted in an emergency, comprehensive geriatric assessment as an inpatient, with ongoing control over medical recommendations, remains the proved intervention as it reduces

mortality, reduces institutionalisation rates, and improves functional status.¹³

- 1 Gravelle H, Dusheiko M, Sheaff R, Sargent P, Boaden R, Pickard S, et al. Impact of case management (Evercare) on frail elderly patients. 1: Controlled before and after analysis of quantitative outcome data. *BMJ* 2006 doi: 10.1136/bmj.39020.413310.55.
- 2 Kane RL, Keckhafer G, Flood S, Bershadsky B, Siadaty MS. The effect of Evercare on hospital use. *J Am Geriatr Soc* 2003;51:1427-34.
- 3 UnitedHealth Europe. *Assessment of the Evercare programme in England 2003-2004*. Executive summary, February 2005. www.dh.gov.uk/assetRoot/04/11/42/24/04114224.pdf.
- 4 Singh D. *Transforming chronic care. Evidence about improving care for people with long-term conditions*. University of Birmingham, Health Services Management Centre, Surrey and Sussex PCT alliance. 2005. www.hsmc.bham.ac.uk/news/TransformingChronicCare.pdf.

Extra references are on bmj.com

Why submit your research to the BMJ?

Because we offer a free high quality service, open access, no word limits, and global reach

Trish Groves

deputy and research editor
BMJ, London WC1H 9JR
tgroves@bmj.com

Competing interests:
None declared.

BMJ 2007;334:4-5

doi: 10.1136/bmj.39057.516250.80

If you're more used to rejection than acceptance letters, you may not believe it when editors say that medical research is becoming a sellers' market. But it's true, at least for investigators "selling" robust and interesting research studies. Medical journals—whether online or print, or both—are falling over themselves and each other to attract research articles, and are becoming bolder about approaching authors who have research articles to publish. Step by step, medical publishing is becoming as much a service industry for authors as an educational and academic service for readers.

What journals offer authors, however, isn't always obvious to researchers choosing a journal. Authors do not want to waste time by sending their research articles to the wrong journal, so the first thing they want to know is whether the editors will be interested in their work. Pure academic interest isn't enough for *BMJ* editors or most importantly for readers, who mainly comprise doctors—whether they're practising clinical medicine, working in public health, developing and implementing health policy, or working mostly as researchers. We aim to provide our readers with articles that will help them to make better decisions.

The *BMJ* is definitely the right journal for studies on the day to day decisions doctors make with their patients. These studies may be randomised controlled trials of treatments and other clinical interventions for patients with common diseases, studies on diagnostic tests, basic clinical observational studies,¹ qualitative studies that help to explain why and how doctors and patients do things, and systematic reviews of all of these study types. The doctors we aim to reach with these articles work in many different settings and countries; most are specialists in hospitals, community units, and clinics or family doctors in primary care. Importantly, the *BMJ* has a dedicated primary care editor² and is still the only high profile general medical journal that publishes original research from and about primary care

every week. The team also includes editors working in clinical practice and research, two of whom are based in the United States.

Decisions about public health and epidemiology can be just as important as clinical decisions; sometimes even more so. So the *BMJ* is also the place for research—much of it observational—that will clearly help to set priorities for public health and to change policy. We give high priority also to studies that provide focused and robust evidence on how and why to offer services and specific types of care to patients, through health services research and qualitative research.

If you're a researcher with an original article that may fit well in the *BMJ*, what can we offer you in return? The *BMJ* offers high international visibility for your work, with immediate free and open access to the full text of all research articles once published, with no charges to authors or readers; immediate transfer of the full text to PubMed Central and the abstract to PubMed, CrossRef, and ISI; unlimited space for online publication with no fixed word limits (we prepare a shorter version for readers of the print edition); rapid decision times with full online publication of accepted research articles as soon as the authors have approved the proofs; copyright retention by author; high impact and visibility; accompanying editorials and commentaries to attract general readers and put research into context for them; and much more (see box on bmj.com).

This autumn we streamlined our editorial process for research articles to give a more personal service to authors, by ensuring that one editor takes each article through from start to finish. And at any time you can track your article's progress through the editorial process at our manuscript website (<http://submit.bmj.com>). The *BMJ*'s team of research editors aims to read 98% of newly submitted research articles within two working days. If your article is potentially suitable for the *BMJ* that editor will ask a senior colleague to

approve it and, if that succeeds, he or she will send your article to two expert peer reviewers who will sign their reports (the *BMJ* uses open peer review).

The next step for your research article, if it is still in the running after peer review and assessment by the *BMJ*'s clinical epidemiology editor, is full appraisal at our weekly manuscript meeting. A statistician, an external editorial adviser, your paper's editor, and the *BMJ* research team will read and discuss your article's importance, originality, and scientific quality and the editor will make the final decision.

If your research article is of exceptional clinical importance and urgency or warrants urgent publication for reasons of public policy, we will gladly consider fast tracking it. We aim to publish accepted fast track articles within four weeks. We undertake that two editors will read each fast track article on the first day of submission; two reviewers will report on it within 48 hours; and it will go to the next weekly manuscript meeting for a decision. We ask authors to revise and resubmit within 48 hours (though this is negotiable).

Competition is tight for *BMJ* research articles; we accepted just 4.9% of them last year. If we are convinced that the *BMJ* is not the right journal for your research article we may read and reject it within the first hour of submission. We hope that you will appreciate the immediate attention we give to your work and our efforts not to waste your time or delay submission elsewhere. We aim to reach a final decision within two weeks on 95% of articles that we do not send for external peer review and in six weeks for 95% of those that we do send to reviewers. On publication the details of each article are transmitted to PubMed, Crossref,

and ISI so that the article immediately appears in the main bibliographical databases. We also send the full text of all published research articles immediately to PubMed Central, the National Library of Medicine's full text archive, which makes it fully accessible without delay. This means that the *BMJ* immediately fulfils the requirements of the US National Institutes of Health,³ the UK Medical Research Council,⁴ the Wellcome Trust,⁵ and other funding bodies in making publicly funded research available to all. The full text of *BMJ* research articles is indexed by Google; we expect other large search engines to follow suit soon.

As well as speedy decision times and open access, we know that authors want space to publish their work. The *BMJ* no longer sets fixed limits for the length of research articles, and we will give you as much room as you need to report your research online at bmj.com in sufficient detail. For the print *BMJ* we will produce an abridged version of your research article, with your approval, to encourage and help readers to engage with and understand it.⁶

Whether you're a researcher, a reader, or both the *BMJ* is your journal. We want you to find it indispensable.

- 1 Rothwell, P. Medical academia is failing patients and clinicians. *BMJ* 2006;332:863-4.
- 2 In brief. *BMJ* 2006;333:770.
- 3 National Institutes for Health. *NIH public access policy*. <http://publicaccess.nih.gov/policy.htm>.
- 4 Medical Research Council. *MRC guidance on open and unrestricted access to published research*. www.mrc.ac.uk/PolicyGuidance/EthicsAndGovernance/OpenAccessPublishingandArchiving/FAQonOpenAccess/MRC003406.
- 5 Wellcome Trust. *Wellcome Trust position statement in support of open and unrestricted access to published research*. www.wellcome.ac.uk/doc_WTD002766.html.
- 6 Müllner M, Groves T. Making research papers in the *BMJ* more accessible. *BMJ* 2002;325:456.

GPs, operations, and the community

Providing good, safe health care is more important than who does it or where it is done

Roger Kneebone

senior lecturer in surgical education
Department of Biosurgery and
Surgical Technology, Imperial
College, London W2 1YN
r.kneebone@imperial.ac.uk

Competing interests:

None declared.

BMJ 2007;334:5-6

doi: 10.1136/bmj.39049.376829.43

Recent dramatic headlines have claimed that general practitioners will be encouraged to carry out operations such as hernia repairs, carpal tunnel decompression, and varicose vein removal.^{1 2} The implication is that general practitioners with little surgical experience will suddenly be picking up a scalpel to carry out operations they are not trained to do. Not surprisingly such a prospect has generated much controversy.

The headlines have been prompted by the government's white paper on community services in the English NHS, *Our Health, Our Care, Our Say*, which proposes a shift in the locus of healthcare.³ The chapter on "Care closer to home" sets out various alternatives to current practice, arguing that patterns of care should adapt to a changing healthcare environment and to the wishes of patients. This means shifting the emphasis towards local services wherever possible.

Are the white paper's proposals really as radical as they have been portrayed in the press (and by some surgeons)? And what are the advantages and disadvantages of changing the balance between primary and secondary care?

In many ways the changes proposed in the white paper are not that radical but build on innovative approaches which have been taking place for years. To anyone practising from the early 1990s onwards, the arguments will have a familiar ring. Many general practitioners carry out minor operations already. And, of course, the debate is not just about general practitioners. The establishment of nurse practitioners and the widening of roles for other healthcare professionals have consistently generated controversy. My experience is that despite initial opposition, such new roles can offer great

benefits, provided their development takes place within a clear framework of training, governance, and audit.⁴⁻⁵ So the question is whether the proposed changes will allow such frameworks to be established and maintained?

Moving care closer to the patient and exploring alternatives to current patterns of practice⁶ offers obvious advantages to patients, including convenience and support from family and community networks. Although sometimes framed around the primary-secondary care divide, the central issue is really about ensuring standards of care, regardless of where and by whom such care is carried out. Any procedure should be necessary, appropriate, performed by a suitably trained clinician and carried out in facilities of a required standard. Effective training and maintenance of skills and practice within an established professional group are essential and must ensure risk assessment, patient selection, recognition of personal limitations, and the provision of suitable backup in case of complications. These requirements should be no different in the community from anywhere else.

Outside a secondary care environment and without its inbuilt checks and balances, the burden for ensuring these standards must rest with the commissioners of care. The commissioners must therefore have effective mechanisms for ensuring standards of governance and for auditing outcomes. But there are worrying indications that this may not always be the case, especially with the treatment of malignant skin lesions.⁷

Cost is clearly another important issue, but it is not easy to establish the true cost of community based treatment. General practitioners with special interests offer high quality care but the service they provide can be more expensive than the equivalent specialist

service offered in hospitals.^{8,9} And there is a danger that offering community based operations will simply increase demand by meeting previously unmet need yet fail to relieve the pressure on secondary care.

So what evidence is there, or will there be, that more specialist services can be safely moved into the community? In the white paper 30 demonstration sites (drawn from dermatology, urology, gynaecology, ear nose and throat surgery, general surgery, and orthopaedics) have been selected for independent evaluation by the National Primary Care Research and Development Centre at Manchester University.¹⁰ Each provides an established example of innovative practice, often challenging boundaries between primary and secondary care and between traditional disciplines. It remains to be seen whether the evaluation will be sufficiently resourced and sustained to provide the necessary level of evidence.

In the end, this is not so much a debate about general practitioners wielding scalpels as about who can best deliver a patient-centred service tailored to individual needs. Patients stand to gain from high quality care offered locally, provided this is delivered within a rigorous framework and effectively monitored by those who commission it. Whether such care is delivered by general practitioners, hospital specialists, nurses, or other practitioners is much less important than the underlying principles of quality and safety. A framework for effective training is crucial, and engagement with royal colleges and specialty associations is key to ensuring quality and safety, especially for the small number of instances where practitioners offer more complex procedures.

Provided the changes are carefully evaluated and the outcomes weighed up before taking action, the white paper's developments have a lot to offer. But history shows the dangers of premature change based on inadequate evidence and driven by political expediency. Avoiding these dangers will be crucial if innovation is to flourish without compromising patient care.

- 1 Ritchie P. Allow GPs to operate? Over my dead body! *Mail on Sunday* 2006 www.mailonsunday.co.uk/pages/live/articles/health/healthmain.html?in_article_id=413643&in_page_id=1774&in_a_source (accessed 17 November 2006).
- 2 Hall C. GPs should leave operations to us, say surgeons. *Daily Telegraph*. 18/10/06 <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/10/18/nhealth18.xml>.
- 3 Secretary of State for Health. *Our health, our care, our say: a new direction for community services*. London: Department of Health, 2006. www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf
- 4 Kneebone R, Darzi A. New professional roles within surgery. *BMJ* 2005;330:803-4.
- 5 Kneebone R, Nestel D, Chrzanowska J, Barnett AE, Younger J, Burgess A, et al. The perioperative specialist practitioner: developing and evaluating a new surgical role. *Qual Saf Health Care* 2006;15:354-8.
- 6 Lewis RQ. A new direction for NHS community services. *BMJ* 2006;332:315-6.
- 7 Schofield J, Irvine A, Jackson S, Adlard T, Gunn S, Evans N. General practitioners with a special interest (GPwSi) in dermatology: results of an audit against Department of Health (DH) guidance. *Br J Dermatology* 2005;153(suppl 1):1.
- 8 Roland M. General practitioners with special interests: not a cheap option. *BMJ* 2005;331:1448-9.
- 9 Coast J, Noble S, Noble A, Horrocks S, Asim O, Peters TJ, et al. Economic evaluation of a general practitioner with special interests led dermatology service in primary care. *BMJ* 2005;331:1444-9.
- 10 Care Closer to Home demonstration sites. Department of Health, 2006 www.dh.gov.uk/assetRoot/04/13/98/18/04139818.pdf.