

4.85 to 8.61 respectively, both $P < 0.001$). Seemingly this is exactly the sort of evidence base to justify measuring both arms, but all studies included in the analysis were of populations at existing high vascular risk, for example, referrals to angiography services. We cannot discover an evidence base that permits extrapolation of the guideline statement to the general population of which it is aimed.

Parker and Glasziou also raise the important issue of how to measure an inter-arm difference. We have found that prevalence of an inter-arm difference is over-estimated without a robust measurement technique.² While this is of epidemiological importance we have found repeated simultaneous measurements to be a barrier to recruitment in primary care⁵ and this approach has been criticised as impractical.⁶ To overcome this we have compared the use of a single sequential pair of measurements to our gold standard simultaneous technique in 187 subjects in primary care with type 2 diabetes. Preliminary findings in 187 subjects have shown a high negative-predictive value of 0.97 in excluding a systolic inter-arm difference > 10 mmHg.⁷ Consequently, the vast majority of subjects who do not have an inter-arm difference can be identified within a single consultation, and only the 10–20% remaining will need further assessment. The validity of this approach, and the clinical implications of detecting an inter-arm difference in subjects at low cardiovascular risk, both require further study.

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Authors' response

We agree with Adjei-Gyamfi *et al* that the reliability of home blood pressure monitoring is crucial to its success. This requires attention to both the sphygmomanometer and the measuring technique. Given around 5% of patients will have a 10 mmHg or more difference between their arms, then an initial check for inter-arm difference is important. However, assessing inter-arm differences reliability requires simultaneous blood pressure measurement, and so this will need to be done in their GP's office rather than at home. At home the patient should then use the arm with the higher blood pressure. Clark and Campbell's suggestion that a single simultaneous pair of measurements may be sufficient to rule out high inter-arm differences appears an important step in making this check practical. However, as they suggest, both the technique and the implications are in need of further research and future blood pressure studies should incorporate dual arm measurement as part of the protocol.

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Nurse practitioners

A recent pilot study published in the January edition of the *BJGP* examined nurse practitioner management of acute in-hours home-visit or assessment requests.¹ The very positive conclusions from this study will not be surprising for anyone working with a nurse practitioner. What is surprising is that the study did not define what is meant by the term 'nurse practitioner'. In the present situation, this is essential. There is no protected or regulated title of nurse practitioner — indeed anyone (not even registered nurses) may call themselves a nurse practitioner.

Most would assume that a nurse practitioner is a nurse who has undergone further training in order to enable her to be able to assess, diagnose, and treat patients. However, it is impossible to say exactly how much or what type of extra training the nurse practitioner has done. As there is no regulated title, there is no specific training. Training courses do of course exist, but they are not mandatory. These courses range from Masters or BSc level (as in the case of the author of this study) to a few days on physical examination carried out by private companies.

It seems ludicrous at a time when GPs in particular are being asked to provide more and more evidence of their fitness to work as GPs in the form of extended training, changes to examinations, and re-accreditation, that there is a group of nurses working in the NHS doing very similar work, with similar outcomes, and patient satisfaction,² with nothing more mandatory than a registered nurse qualification.

Patients are confused and their safety is put at risk by this situation where there

is potentially a huge disparity between nurses practising as nurse practitioners. Employers may equally be confused and unclear as to what to expect from the nurses. Nurse practitioners themselves are frustrated at constantly needing to explain who they are and what they do to patients and colleagues, and are distressed at the potential for damage and harm in this situation.

The Nurse Practitioner Association of the Royal College of Nursing have been working to rectify this situation over the past decade. The Nursing and Midwifery Council have agreed competencies and educational levels for nurse practitioners but are unable to enforce this until the government agrees the legislation. In most other countries where nurse practitioners practice there is a regulated title that allows a recognised level of education and training and would allow re-accreditation.

This situation affects research as well as practice in terms of transferability of studies as there is nothing standardised about either the title or the training of nurse practitioners. Other practices could not therefore, assume that their nurse practitioner was equally qualified or prepared to do the same work.

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Authors' response

We would echo Wendy Fairhurst's frustration with the lack of consensus definition of a 'nurse practitioner', and the myriad different qualifications and levels of experience which (generally self-styled) nurse practitioners variously demonstrate.

Indeed, this issue caused the first author (ME) some initial confusion when this study was conceived. Space precluded a detailed description of the qualifications and experience of the single nurse practitioner (CB) employed in our study, and the lack of any established criteria essentially meant that, for us to offer a definition of nurse practitioner as Fairhurst suggests, would involve listing CB's entire four-page CV — which further reinforces Fairhurst's point (a CV is however, available on request). Nurse practitioners find themselves in a situation analogous to that of GPs, and their predecessors the surgeon-apothecaries, in the first half of the 18th century: facing competition from less qualified and less experienced colleagues who were entitled, under the 'laissez-faire' politics of the day, to bill themselves as professional equals. Half a century of lobbying and the formation of many GP associations (mostly short-lived, although one survives today as the British Medical Association) culminated in the Medical Act of 1858, establishing unified standards of training and qualifications for all doctors. We hope that it will not take another 50 years to establish a similarly unified and recognised curriculum for nurse practitioner training.

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Clinical researchers

I am glad I seem to have initiated a debate about practice-based research and its publication in the *BJGP*, but find myself accused as thoughtless by a guru and ignored by College prelates who responded to his blast concerning his own agenda.

My initial letter¹ was to support Ian McWhinney's concern about the lack of

publication of research on clinical insight or discovery by GPs. The Editor of the *Annals of Family Medicine* responded immediately by inviting submissions on 'emergent discoveries based on careful clinical observation' from its readership. The Editor of the *BJGP* has made no such offer. Julian Tudor Hart presumes that I (and presumably McWhinney) have not thought deeply enough about the issue but also urges us all to have an unshakeable faith in the Editors' wisdom and insight in the matter.² He has no doubt that if good clinical research by GPs in their own practices were submitted, the Editor would be delighted to publish it.

There the matter might have rested had his rambling tirade not been responded to by three College representatives,³ and they demonstrate why I was probably correct to be concerned. It seems that clinical researchers in general practice are indulging in 'occupational therapy for doctors' and they declare, seemingly on behalf of the College, their belief that the days of the 'gentleman amateur' working to produce research in a general practice 'cottage industry' are now over. It seems that GPs now have to be members of research networks before they can be researchers. Presumably, it will only be these fortunate enough to rise to the top of these pyramid schemes who will qualify for the RCGP Discovery Prize for original research in general practice.

I may not have thought deeply enough about all this but it was my impression that the discipline of general practice was about the delivery of primary, personal, and continuing care of individuals, families, and practice populations. It is therefore, imperative that research is carried out by individual GPs in their own practices, and for three College prelates to suggest otherwise is outrageous. Of course research networks are important and we must encourage the academic activities of academic departments, but these will only produce abstractions and generalisations about general practice, which are only one side of the story. As McWhinney pointed out, quoting from James, we also need 'an acquaintance