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Authors' response

We considered Aabenhus and colleagues' comments about the shortcomings of our article. However we disagree with the main points in their letter. First, initially, we noticed that Cals *et al* may use the same dataset to publish duplicate studies. However, their results are different. In order not to miss any studies, we conducted the analyses both including them and excluding them. We found whether to include or exclude them would not affect the overall results. In this systematic review, we did not want to miss any studies that met the inclusion criteria.

Secondly, C-reactive protein (CRP) is a kind of biomarker for improving the assessment of infection. CRP is an inherent and natural inflammatory protein in patients irrespective of where a patient is, such as in primary care or emergency. The relationship of CRP to infection does not change. With the same condition, first contact may be flexible in primary care or accident and emergency; thus, we also included Gonzales' study. In addition, the sample size in Gonzales' study is very small and the exclusion of this study did not affect the results.

Thirdly, Aabenhus and colleagues are wrong. There is no Figure 2a in this study. We assume they meant Figure 3a, which studied antibiotic prescribing at any time during the 28-day follow-up. All the studies included in Figure 3a have same effect measure.

Finally, there were many publications of meta-analysis which combined the results from both randomised controlled trials and observational studies, such as cohort studies. In our study, we had already

conducted subgroup analyses according to the study design.

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Editor's note

Readers are invited to comment on this correspondence, in which some methodological questions about the selection of studies and patients for the meta-analysis are discussed.

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Patient experience and GP trainees

The contribution of GP trainees to individual practices and to national data on patient experience is often not emphasised, or perhaps undervalued. I would be interested in clarifying what proportion of consultations within these training practices in the study by Ashworth *et al*,¹ were conducted by its trainees. How much, if at all, does the patient experience at training practices reflect interactions with its GP trainees?

Indeed we have longer consultations, and financial or administrative targets are a lower priority. When I commenced GP training, most of us had a wonderful 15–20 minutes for each appointment. If my trainer sat in with me for joint surgeries, there was even more flexibility in the consultation. During these extended consultations, we had the time and opportunity to really understand our patients, explore their worries and experiences of the disease rather than simply treating biochemical markers of a disease.^{2–4} The patient was my only priority. As I come to the end of GP training and experience the reduced 10-minute appointments, increases in tick-box targets and administration, my consultations are changing and inevitably the patient experience will do so to.⁵

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Knowledge and attitudes of waterpipe tobacco smoking among GPs in England

Waterpipe tobacco smoking (WTS) is a growing public health concern. This exploratory study sought to assess the WTS knowledge and attitudes of healthcare professionals by distributing an anonymous, 12-item, cross-sectional survey to GPs in two areas; Brent: a socially-deprived, ethnically-diverse area of outer London known for its high prevalence of WTS¹ (response rate 49 out of 251 [19.5%]), and Lancashire: an area of the north west of England not typically known for its WTS popularity (response rate 113 out of 850 [13.3%]). Questions asked about WTS consultations, beliefs, and smoking prevalence among GPs.

Out of 154 GPs, 31.2% were from Brent. More Brent GPs had previously given advice to patients about WTS (36.7% versus 13.0%, $P<0.01$) and previously asked patients about WTS as part of a tobacco history (32.7% versus 12.0%, $P<0.05$) than Lancashire GPs. Very few GPs had read about WTS in the academic literature (8%) compared to news media (29%), 19% had given advice to patients about WTS, and only 16% were confident in giving accurate WTS information to patients. Over half of GPs correctly answered our WTS knowledge questions about the harms of WTS. Half made an attempt to estimate the equivalent number of cigarettes that are consumed during one WTS session, which is estimated to be around the 10 cigarette