LETTERS

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A recruitment crisis paradox

Sir,

In a recent editorial (January *Journal*), Mathie reiterated the need to train more doctors as general practitioners (GPs) in order to resolve the recruitment crisis, and noted that trainee numbers have been inflated by non-UK EEC graduates.[1] A further potential source of trainees ignored in the editorial is non-EEC graduates; however, Home Office regulations effectively prevent this latter group from working as GP registrars.[2] The regulations prohibit the reimbursement of the registrar's salary, and, as a condition of the required Training and Work Experience Scheme permit (TWES), the registrar must leave the UK at the end of the training period. The government's rationale for this rule is based on the mistaken belief that GP registrars — the future of general practice — are supplementary. Thus, paradoxically, a non-EEC doctor can work as a GP in the UK on the basis of appropriate foreign experience (with a work permit), but cannot, in fact, train within the health service in which he or she wishes to work.

Although there are no obstacles to the completion of the hospital component of GP training, non-EEC trainees are unable to fulfil the requirements for the Joint Committee Postgraduate Training for General Practice certification. The situation is similar for non-EEC colleagues wishing to complete specialist training, who are being denied Calman numbers if they do not have the right of residence in the UK. Such 'partial' training is wasteful of resources and will not serve to alleviate the recruitment crisis currently facing the National Health Service. Although the British Medical Association's International Department are seeking a change to the regulations, a public statement of support from the Royal College of General Practitioners for non-EEC doctors wishing to train as GPs would be most welcome. Such support may even lead to decisive action.

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Resuscitation by general practitioners

Sir,

I would like to comment on the editorial by Dr Colquhoun (January *Journal*) on resuscitation by general practitioners (GPs). I would have thought that the summation of evidence with regard to the management of acute chest pain that may be caused by a myocardial infarction, over the past decade or so, is such that GPs would not be the best–placed people to carry defibrillators. In our area of the country we, as most others do now, have paramedic ambulances that carry defibrillators. It is well known that the earlier a patient arrives at hospital, and the earlier a patient receives thrombolysis, the better the outcome. I suspect that calling a GP first only delays the start of definitive treatment. Also, with the advent of GP cooperatives and urgent care centres, especially where large areas are covered, rapid GP response to chest pain can be quite difficult to ensure.

Given all the above, I feel that ambulance and paramedic response to cases of chest pain triaged on the telephone at the urgent care centre, is quicker and more appropriate. In addition to this, the service already has in place regular and updated resuscitation courses for its paramedics and '999' ambulance staff, whereas I would imagine that it would be a long time before GPs will agree to mandatory re-training in resuscitation skills.

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Sir,

A recent editorial and article (January *Journal*)[1,2] strongly commend the role of general medical practitioners in cardiopulmonary resuscitation (CPR) in the community. However, both neglect to consider the cost of their suggestions.

Repeated training is costly, both in time and in funding. Numerous studies show that training needs to be repeated regularly to be effective. Defibrillators cost several thousand pounds each, would be needed by any partner who did home visits, and would incur servicing and replacement costs. Will the practice bear these costs pro bono or will they fall on the public purse?

Would the equipment be carried into the home at each visit? West and Penfold comment that 'only 35% would have been able to administer oxygen'; more carried intubation equipment. All of this fits in a car boot, but how much is actually going to go down the garden path? An anecdotal survey of GP friends suggests that cardiac arrests witnessed by any single GP are rare.

Both contributions fail to recognize the changes over the past few years that have taken place in the ambulance service. Nowadays, most parts of the country can expect a rapid response by a paramedic-crewed vehicle. The crew would have all the apparatus and the recent clinical experience and training to institute CPR and

treat arrhythmias. I believe that for the vast bulk of the UK population this is the way to provide CPR in the home.

GP-led CPR, like domicillary thrombolysis, has a place in rural parts of the UK, but for most of the country the need is to fast track acute ischaemic heart disease to an emergency room in a hospital. Even a home visit might cause needless delay, and the best scheme would only rarely leave a GP with a patient awaiting an ambulance. Successful fast tracking, not occasional CPR, does more to improve survival.

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Sir,

The assertion that 5% of patients a general practitioner (GP) attends with a myocardial infarction (MI) will have a cardiac arrest in his or her presence may be an overestimate.[1] It is derived from two studies:

1. Of 928 patients seen with an MI, 56 (6.0%) had a cardiac arrest 'in the general practitioner's presence or so recently before his or her arrival that resuscitation was considered'. Of these, 13 survived to leave hospital.[2] The low success of resuscitation in this study, where 80% of the doctors were equipped with defibrillators, suggests that many of these individuals were already dead before the doctor arrived.
2. In a randomized controlled trial of domiciliary thrombolysis, 15 of 311 (48%) patients with a strong clinical suspicion of MI, with a duration of less than four hours, had a cardiac arrest. Seven of these patients survived to leave hospital.[3] This group of patients, who were suitable for inclusion into a randomized controlled trial, and who were at high risk because of the short duration of symptoms, may not be typical of those seen by GPs.

Both studies were based in the Grampian region before the widespread introduction of out-of-hours cooperatives and the recommendation of joint GP and ambulance attendance at MIs.[4] These data may not be representative of current experience across most of the UK.

The presence of a lone GP at the onset of ventricular fibrillation following an MI is probably less common than suggested. Anecdotal evidence to support this can be obtained by asking a few senior colleagues how often this has happened to them over their working life; a question unlikely to be prone to much recall bias. It is therefore surprising that West and Penfold[5] found that as many as 30% of Suffolk GPs, none of whom worked for a cooperative, carry a defibrillator when on call. It is difficult to believe that the purchasing of defibrillators by practices is the best means of delivering the service, not least because of the problem of making sure that the practice defibrillator is in the right place at the right time.

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Spirometry in general practice

Sir,

The paper by den Otter *et al*[1] (January *Journal*), reporting a videotaped assessment of the performance of practice assistants conducting spirometry in general practice, was timely and informative. Timely, because British Thoracic Society guidelines for the management of chronic obstructive pulmonary disease are to be published soon and can be expected to include recommendations for the measurement of ventilatory capacity (FEV_1 and FVC) in primary care; and informative, because their brief report highlighted specific deficiencies in performance that need to be targeted by those running training courses for spirometric 'technicians' in primary care.

The authors chose not to discriminate between the 12 scored items with a kappa coefficient greater than 0.60, presumably because these indicators of process were not linked to outcome measurements such as the American Thoracic Society's (ATS) acceptability and reproducibility criteria.[2] Readers may well ask which indicators of performance really matter. There is probably no need to conduct research in primary care linking process to outcome in spirometry, since we can take a short cut and learn from extensive experience in the pulmonary community. Specifically, we can ask where the emphasis has been placed in studies that have delivered spirometric measurements with good quality control.

In the Lung Health Study (LHS),[3,4] only 2.1% of test sessions failed to achieve the ATS recommendation (current at the time) that the two highest measurements of FEV_1 should agree within 5% or 100 mls. The LHS placed particular emphasis on technician performance and training to ensure that they demonstrate the FVC manoeuvre before the participant's first attempt, vigorously coach to obtain a 'blast' at the onset of the manoeuvre, observe the participant throughout the manoeuvre, and give enthusiastic positive feedback to encourage maximal efforts.[4]

Spirometry in the LHS included other features, such as detailed participant preparation, improved spirometer design with real-time quality control messages, and regular feedback to spirometric technicians about their performance.[4] Although some of these features might be inappropriate or too expensive for a primary care setting, it is still clear from this and other studies that spirometric 'technicians', whether they be general practitioners, practice assistants or practice nurses, must first demonstrate the FVC technique themselves and then coach their participants. Both of these aspects of technician performance were conducted poorly in den Otter's study, where it was particularly revealing that the notion of providing verbal encouragement embarrassed their practice assistants, reminding them of the behaviour of football coaches. Perhaps a more fertile analogy is the encouragement provided by midwives during the second stage of labour.

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ALS courses: positive action needed in general practice

Sir,

West and Penfold's paper (January *Journal*)[1] clearly demonstrates the need for advanced life support (ALS) courses for doctors in primary care. There are, however, several issues that need to be addressed. First is the targeting of those doctors who have not yet attended an ALS course or those who have but simply need an updating of their skills and recertification. The establishment and maintenance of a register should ensure these goals are achieved. Second is the attendance of standardized ALS courses specifically, rather than less comprehensive courses, as this will ensure proper training to the expected level of competence. Third is a consideration of courses exclusively for general practitioners; currently ALS course attenders include professionals of varying grades, which may make some general practitioners wary of attending such courses unless obliged to do so. Last is motivation by means of incentives. Postgraduate Educational Allowance approval and reimbursement of fees are two ways that could generate increased attendance at such courses.

As the authors state,[1] 'in community hospitals in the United States, practitioner attendance at advanced life support courses favourably affects the overall practice of resuscitation and increases the survival rate of patients with ischaemic heart disease'.[2] Isn't it time we also took positive action in implementing such changes in general practice?

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A questionnaire survey of resuscitation equipment

Sir,

Cardiac arrest is encountered rarely by some general practitioners (GPs) owing to practice age profile and increasing use of deputizing services and cooperatives for on-call work. Whatever efforts are made in continuing education, it is not surprising that GP skills in the management of cardiac arrest are poorly maintained.

Compared to many GPs, ambulance paramedics (and it is policy in many regions to have at least one paramedic per crew) are more likely to have the knowledge, skills and equipment necessary to manage cardiac arrest. In addition, ambulances in many parts of the country are capable of a faster response time than GPs. It is not realistic or sensible to imply that the increasing role of the ambulance service in this matter, with a lesser one for GPs, 'is unacceptable'.

In an under-resourced health service, the first priority for being equipped with defibrillators should lie with larger health centres, out-of-hours primary care centres and deputizing service cars. How many of these are equipped with defibrillators?

Incidentally, according to current EEC guidelines, a precordial thump is a correct initial action in a patient in ventricular fibrillation having a proficient basic life support, only if the arrest was witnessed.

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Taking patient histories

Sir,

Taking patient histories can be time consuming. We have previously reported[1] that pre-consultation questionnaires improve the quality of a consultation. As an alternative to paper and pencil questionnaires, we have now evaluated the use of computer-presentated questionnaires where the patient responds by touching a horizontally placed screen using a pen computer (Compaq Concerto). We evaluated the acceptability and reliability of the Asthma Bother Profile[2] presented by computer in 39 asthmatic patients (age range 18–65). Eleven patients completed the electronic version twice, and 13 patients completed the paper and pencil version twice with an interval of three weeks. Retest reliability for total scores was 0.997 for the electronic and 0.694 for the paper and pencil versions. Fifteen patients completed both the electronic and paper and pencil version three weeks apart, with the order of presentation counterbalanced. Of these patients, 12 preferred the electronic format, two preferred the paper and pencil and one had no preference. Age was unrelated to preference. Reasons given for preferring the electronic version were: quicker (6), easier (5), more private (2), state-of-the-art/newer (2), fun to use (1). Reasons for preferring the paper and pencil were: able to take it home (1), easier to follow and answer (1).

We conclude that electronic questionnaires provide a reliable and acceptable method for collecting patient data, and may lead to more time-effective consultations.

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Do GPs agree with 'old' sensible drinking limits?

Sir,

The longstanding guidance on sensible drinking limits has received wide international endorsement. Following reports of a J-shaped relationship between levels of

consumption and some types of harm, the issue has been re-examined, and support for these drinking limits has been re-affirmed.[1,2] The surprise proposal[3] to raise the limits substantially for both men and women attracted major criticism,[4] especially in view of recent failure to make progress towards the targets for alcohol reduction set out in the *Health of the Nation* report.[5] The implementation of a population-based approach to reducing alcohol consumption is crucially dependent upon the involvement of general practitioners (GPs). What opinions do GPs hold about the pre-existing sensible drinking limits?

Face-to-face structured interviews were undertaken during mid-1995, with a random sample of 200 GPs across England and Wales, stratified by sex, age and Family Health Service Authority. The interview included an enquiry about the doctors' opinions regarding the existing guidance on sensible drinking limits. Valid responses on these items were obtained from 195/200 (98%) of the GPs.

The study sample were 78% male, having qualified in the 1950s (7%), 1960s (21%), 1970s (36%), early 1980s (29%), and post-1985 (8%); 32% worked in fundholding practices.

Only 22% (42) of GPs considered the drinking limits for men to be 'too low', with 76% considering them 'about right' or 'too high' (127 (65%) and 21 (11%) respectively).

There was high correlation between responses from practitioners for the limits for men and for women (Pearson's r = 0.61, P<0.0001). For 83% of respondents (162/195), the views on men's and women's limits matched. These responses were also considered against practitioner characteristics (Table 1). No significant differences were found in the responses from doctors who considered the limits 'too low', except a tendency for doctors who were more recently qualified to consider the drinking limits for women to be 'too low' (χ^2 for linear trend = 3.48, P<0.1).

We conclude that there is broad support from GPs for the pre-existing sensible drinking limits. Less than a quarter considered these limits to be too low. The minority of GPs who thought that the limits were 'too low' were more often male, and working in non-fundholding practices. For the majority of practitioners, no increase in the limits seemed indicated. If we seek real progress towards the *Health of the Nation* recommendations, then, on the basis of our findings and other scientific evidence,[1] the pre-existing sensible limits should be retained, and GPs should continue with 'business as usual'.[4]

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Table 1. General practitioners opinions of the 'old' sensible drinking limits.

Do you consider these limits for men…?		'too high' 16% (31/195)	'about right' 63% (122/195)	'too low' 22% (42/195)
By sex	Male GPs (n=151)	13%	64%	23%
	Female GPs (n=44)	25%	59%	16%
By year of qualification	Pre 1960 (n=12)	42%	42%	17%
	60s (n=41)	17%	56%	27%
	70s (n=68)	15%	68%	18%
	80s (n=58)	12%	64%	24%
	1986 onwards (n=15)	7%	73%	20%
By funding status	Fund-holding practice (n=60)	17%	67%	17%
	Non-fundholding (n=135)	16%	61%	24%
Do you consider these limits for women…?		'too high' 16% (31/195)	'about right' 63% (122/195)	'too low' 22% (42/195)
By sex	Male GPs (n=151)	10%	64%	27%
	Female GPs (n=44)	14%	71%	16%
By year of qualification	Pre 1960 (n=12)	33%	50%	17%
	60s (n=41)	17%	68%	15%
	70s (n=68)	12%	65%	24%
	80s (n=58)	3%	64%	33%
	1986 onwards (n=15)	0%	73%	27%
By funding status	Fundholding practice (n=60)	13%	68%	18%
	Non-fundholding (n=135)	10%	64%	27%

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Breastfeeding and health in the Western World

Sir,

I read with interest the recent review (October *Journal*) and subsequent letter on breastfeeding in the Western world.[1,2] Patrician Muirhead describes an exciting practice team effort to promote breastfeeding and makes the point that the common reasons for stopping are preventable if good techniques can be taught and plenty of support given.

In a prospective study of all patients attending the antenatal clinics of a large group practice in Nottingham in 1991, I found that while 94% agreed breastfeeding was better than bottlefeeding, only

Table 1. Sources of help with infant feeding.

	Number of mothers
In hospital:	
Hospital midwife	33
Partner	3
Mother	1
At home:	
Community midwife	50
Partner	18
Health Visitor	13
Mother	11
General practitioner	5
Friend	4

Postnatal responses: n=74; some mentioned more than one source.

76% intended to breastfeed. In fact, 80% actually started breastfeeding, but 32% had stopped by the postnatal check.[3] Twenty-seven per cent of breastfeeding mothers gave their first feed more than three hours after delivery, and 32% of the breastfed babies were given supplementary feeds on the postnatal ward: both these practices are known to increase the risk of breasfeeding failure.[4,5] Every first-time mother needed help with breastfeeding, and 25% of mothers who had breastfed before needed help again. The majority of this help came from midwives (Table 1); sadly the role models who influence the choice to breastfeed (mothers and friends) played little or not part in encouraging or supporting breastfeeding.

It is interesting to see what an influential role the midwife has in supporting and advising on breasfeeding. Midwives who are not fully supportive or do not understand the techniques or physiology of breastfeeding will be unable to encourage the breastfeeding mother.

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Repeat prescribing

Sir,

The articles by Zermansky, and Harris and Dajda (November *Journal*) have expanded and updated our knowledge of repeat prescribing in England. However, there are some aspects of repeat prescribing that they have not investigated on which we can provide some limited data from a study we carried out in an inner city Birmingham practice. The study was carried out in May and June 1996 in a practice with a population of 9420, of whom 11% are over 65 years old, and for which the practice receives deprivation payments for 65% of the patients. The practice has used the VAMP computer system to record all prescriptions and patient morbidity (the practice is a contributor to the RCGP/OPCS morbidity surveys) since March 1988. For a 28-day period, all patients requesting a repeat prescription were identified and their computer records examined to determine the medicines they were receiving on repeat prescription and the complete list of medical problems for which they were being seen.

Over the 28-day period, 259 (2.8%) patients received a repeat prescription (16 patients received two repeat prescriptions within the study period). This is quite low compared with the figures in the range 16% to 20% noted in the National Audit Office study of repeat prescribing.[1] These 259 patients received a total of 907 items on repeat prescription, which was estimated to represent 15% of all prescription items issued during the study period, which is again a much lower figure than that quoted in other studies such as Zermansky or Harris and Dajda (November *Journal*). Each patient was receiving an average of 3.5 items, the maximum number of items received by any one patient being 13. Forty-two and a half per cent of the patients were receiving more than four items on repeat. These compare with the average of 4.2 items per patient and 35% on four or more items reported by Purves and Kennedy.[2]

We examined the combinations of drugs patients were on for potential drug interactions using the listings of drug interaction in the British National Formulary (BNF) (No. 31, March 1996).[3] One hundred and twenty-one (47%) of patients were receiving combinations of medicines said by the BNF to be capable of drug interactions. However, many of these combinations could be justified clinically in many circumstances, and they represent drug interactions that may be harmless or only rarely a source of morbidity. Thus, the commonest potential interaction identified was that between inhaled beta-agonists and corticosteroids, which are said to induce hypokalaemia at high doses, and yet this combination is recommended in the British Thoracic Society guidelines for the management of asthma.

However, even when we confined our search to those combinations noted by the BNF as potentially hazardous (i.e. 'where combined administration of the drugs involved should be avoided or only undertaken with caution and appropriate monitoring'),[3] 36 (14%) of the patients were found to be on one or other of 51 such combinations. In 30 cases, the two drugs are often used to treat the same condition. For example, there were four instances of combined anti-epileptic drugs, and seven of drug combinations used in the treatment of cardiovascular disease (ACE inhibitors and loop diuretics, for example). In 21 instances, however, the drugs in combination were obviously being used for different conditions and the combination is more likely to have been avoidable. In 12 instances, the combination included an ACE inhibitor; in 10 instances, one or other of the drugs was an anti-epileptic drug, and in five instances, one of the drugs concerned was warfarin.

Like Zermansky, we also examined the extent to which repeat prescriptions were being reviewed. Although we found that 349 (38%) of the 907 items were issued to patients after the review date set by the computer system (meaning, in effect, that the computerized recall system had been overridden), only seven patients (3%) had not actually been seen for over one year — this compares with 72% not reviewed in Zermansky's study. This suggests the computer system is setting a review date at intervals more frequent than is, perhaps, deemed clinically necessary. We also examined the link between the drugs being prescribed and recorded patient morbidity. In 34 (13%) cases we could find no appropriate indication for one or more drugs being prescribed; although, again, this compares favourably with Zermansky's figure of 56% for prescriptions without clear evidence of a decision to prescribe long term.

Our study confirms that, even in this practice with a low rate of repeat prescribing and some evidence of fairly tight control, there was room for improvement. Furthermore, our evidence suggests that another important aspect of repeat prescribing worthy of further exploration is the extent to which it contributes to the occurrence of polypharmacy and possible hazardous drug interactions.

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Symphysis pubis dysfunction

Sir,

Recently, the Association of Chartered Physiotherapists in Women's Health (ACPWH) organized a meeting to raise the awareness on symphysis pubis dysfunction (SPD) amongst those responsible for women's health. This applies particularly to general practitioners and obstetricians.

SPD is not a new condition. In 1870, Snelling described abnormal relaxation of the pelvic joints, including the symphysis pubis, leading to distressing symptoms.[1] Over a century later we still fail to recognize the condition and offer appropriate support.

The classic features of SPD include pain over the symphysis pubis, locomotor difficulty, and occasionally symphysial clicking. There may also be low back pain. Locomotor problems include pain exacerbated by walking and movements where weight is transferred onto one leg (e.g. climbing stairs). The condition may arise in the antenatal period, intrapartum or in the puerperium. One study showed a postpartum incidence of 1 in 800 deliveries.[2]

The diagnosis of SPD is essentially clinical but various imaging techniques may have a role. Originally, plain X-ray was used to measure the interpubic gap, but this is now accomplished by ultrasound scanning without exposure to radiation. The interpubic gap was abnormally wide in symptomatic women (median 20 mm) compared with a control group (4.8 mm).[2] The upper limit of normal was taken as an interpubic gap of 10 mm. Magnetic resonance imaging has also been used. It has demonstrated soft tissue injury with symphysial cartilagnious clefts in women with peripartum pubic symphysis rupture.[3] This is in keeping with postmortem findings of mechanical damage to the symphysis pubis joint in women delivered vaginally of a baby weighing more than 2.3 kg.[4]

Once diagnosed, the help of an experienced obstetric physiotherapist is essential. They will be able to give appropriate advice on exercises to be encouraged, manoeuvres to be avoided (e.g. the lithotomy position in labour if possible), rest, trochanteric belts, and elbow crutches to aid weight-bearing activity. Analgesia has an important role too. This includes simple analgesics (e.g. paracetamol), non-steroidal anti-inflammatory drugs and opiates. It may be necessary to involve the pain relief team. Occupational therapists will be able to advise on appropriate aids at home, both antenatally and postnatally, and, in intractable cases, orthopaedic assessment and joint stabilization may be needed.

Recognition of SPD will reduce morbidity (pain, depression and relationship difficulties).

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Defeat depression

Sir,

I write as a general practitioner (GP) and a district GP tutor and associate adviser in general practice. I am an enthusiast for the effective treatment of depression, but am well aware of the difficulties facing our peers at the coalface.

I have been locally involved with the Depeat Depression campaign over the past five years, and am aware that there has been some disappointment about the difficulty in taking the messages of the campaign, and of mental health topics in general, to GPs.[1] It is perceived that it has had little impact on changing professional practice.

I think we need to make clear the messages about team-working in the care of patients with depression, and help put some of these ideas into practice.[3] We need easy-to-use training and skills packs that can be taken to practices and locality groups by non-specialist facilitators and trainers. It is also important to acknowledge that letting go of work that has always been perceived as 'medical' may not be easy for doctors.

A prerequisite for effective education is that the practice must be aware of what its learning needs are. Few doctors would disagree that they want to give their patients appropriate and effective treatment in line with the current view of best practice. Starting from that basis, there might be interest in supplying GPs and their teams with a summary of what we believe is effective management, and offering them a simple tool with which they can measure their own performance against these standards. The support of local MAAGs or their successors would be essential, as would some financial help to give practices protected time to review the results and plan change.

Finally, I think there is an opportunity to

Depression is:
- Common (as common as asthma or hypertension)
- Recognizable by specific features
- Potentially fatal (3000 deaths a year)
- Expensive and time-consuming if missed
- Treatable with effective interventions

But…
- It is often treated with sub-therapeutic drug doses
- Treatment is often not maintained long enough
- Patients' compliance is often poor

The facts
- Use of a checklist can allow major and minor depression to be distinguished
- Drug treatment has only been shown to be effective in major depression; support and review may be enough in minor episodes
- Adequate drug doses are required — at least 125 mg daily of tricyclics and full standard doses of SSRIs (e.g. 20 mg Fluoxetine or Paroxetine)
- At least three months drug treatment in a first episode and six in a subsequent episode is indicated
- Patients' compliance can be increased by their involvement in treatment decisions and by addressing their fears about drug therapy — often ill founded

publish and distribute a single sheet summary of current recommendations for all team members. I append a possible form for this.

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GP training in dermatology

Sir,

The current lack of training of general practitioners (GPs) in dermatology should be a major cause of concern to all those involved in primary care. In a survey of consulting trends in general practice, 15% of the study population consulted for a dermatological problem,[1] yet some medical schools provide little or no formal dermatological training. The extent of the problem, and solutions presently available, are worthy of further discussion.

A survey has highlighted the lack of dermatological training in vocational training schemes, with only 28 out of 160 mentioning dermatology.[2] A newsletter of the All Party Group or Skin, mentioned a forthcoming report on the enquiry into provision of dermatological services in primary, secondary and tertiary levels in the United Kingdom. This report is expected to look closely at difficulties relating to the training of GPs in dermatology.[3]

The Primary Care Dermatology Society (PCDS) was formed in 1994. It is open to all GPs with an interest in dermatology, and is a registered charity. The PCDS provides a forum for GPs with a common interest in dermatology to exchange views and ideas, encourage research and promote education. The PCDS wishes to encourage links with specialists and specialist groups. It is affiliated to the British Association of Dermatologists, is part of the Health of the Nation working party on skin cancer, and is a member of the All Party Working Group.[3] We hope to work with other interested groups in order to reverse the declining level of training that GPs are currently receiving in dermatology.

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Implications of proposals made by *BJGP* authors

Sir,

Is it not time that the authors of the *British Journal of General Practice's* (*BJGP*) papers gave some idea of the implications, at least in labour and cash, of any proposals that they make? For example, look at the resuscitation articles in the January issue. Dr Colquhoun refers to defibrillators as 'expensive' but gives no figure. He recommends courses but does not say how long they last nor what they cost. Drs West and Penfold also recommend courses, at least in their summary; the only mention of cost is that someone else should pay for it!

Neither paper mentions the cost of maintenance and replacement of equipment: the conditions in a GP's car are pretty poor — temperature –10ÞC to +50ÞC, for instance. Neither paper mentions the fact that a call that implies immediate attendance means that other work has to be done late, by somebody else, at a cost, or not done at all. Neither covers the question, raised by implication by West and Penfold, of whether thrombolytics might not save more lives than the 5% saved by resuscitation, at far lower total cost.

The risk is that a paper in the *BJGP* may be taken to be the only legally defensible way of doing something, regardless of whether it is practical in the real world of general practice.

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