Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Breast feeding

Hoddinott *et al*[1] report significant associations between certain socioeconomic factors, available emotional support, and predicting which mothers will stop breast feeding before three months. While their results were applicable in an inner-city setting, we have some concerns about the conclusions drawn from missing data.

Women who were non-attenders to child health clinics were excluded from the study; however, there were no further details of these women. It is important to compare these non-attenders with those women who took part in the study. It is likely that women who do not turn up to healthcare appointments are also those least likely to know of the benefits of breast feeding and lack the practical and emotional support the authors conclude is a significant influence on continuity of breast feeding.

The missing data consisted of questions about socioeconomic factors, previous experience of breastfeeding, and a health visitor assessment of emotional support. We feel that a remainder questionnaire, or another type of follow-up to complete the dataset and eliminate bias would have been valuable, as factors were unlikely to have changed in a short time period (three months), and the questions were not intrusive. The missing data were also of concern to us because there was no breakdown of which 25 mothers were excluded because of it. The authors have already grouped all non-white ethnic groups together, despite probable cultural differences, and concluded that school-leaving age is not a significant factor in ethnic women in their decision to continue to breastfeed. This seems a hasty conclusion to draw, considering the small proportion of women of differing ethnicity (58 out of 296) included in the study, especially if any of these women were in the 25 excluded because of missing data.

Have the authors considered the Hawthorne effect? There is no mention in the paper of whether the participating women were told of the purposes of the study. Assuming that the participants were informed of the study purposes, it is likely that the extra attention they received from their health visitor could have affected their attitudes to breast feeding and their determination to continue with it if they experienced problems. This may be part of the reason underlying the higher percentage of women continuing to breastfeed in this study compared with others published previously.[2]

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Authors' response

We agree with Egbeare *et al* that a 100% response rate to surveys is ideal. Our response rate of 93% (279 out of 302) is better than the 1995 National Infant Feeding Survey (NIFS)[1] which achieved a response rate of 74% at 6–10 weeks after birth after two postal reminders. The 23 (not 25 as Egbeare *et al* state) non-attenders at health clinics may be less likely to know about the benefits of breastfeeding. The aim of our study was to predict which women who initiated breastfeeding would still be breastfeeding at three months. It is likely that some of these non-attenders would not have chosen to initiate breastfeeding anyway, so their data would have had no effect on the study findings. There is also an ethical question about how appropriate it is to pursue people who choose not to use health services.

As we mention in our discussion, it was necessary to group non-white women owing to small numbers. We agree that this is far from ideal and is worthy of further research. We are not aware of any other study that has looked at age of leaving full-time education, ethnicity, and breastfeeding duration in Britain. If other studies confirm our finding that age of leaving full time education at 16 years or below is only a significant predictor of breastfeeding duration for white women, this has important implications for future research, in particular NIFS, which does not currently collect data on ethnicity.

Women were not told that the aim of the study was to look at breastfeeding duration. Women were asked to consent to the usual information collected at the new birth visit and the three-month visit to be recorded on a data collection sheet for audit and research purposes. Our higher number of women continuing to breastfeed could be due to the Hawthorne affect as the health visitors were all committed to the study and keen to promote breastfeeding, as are most health visitors. Equally it could be due to being in London, which is known to have higher breastfeeding rates than other areas in Britain.[1]

This study falls into the grey area between audit and research. In primary care, vast quantities of information are collected but it is seldom recorded systematically. This is a low-cost pragmatic study in a normal clinical care setting. There was no additional funding for the health visitors to collect the data. We illustrate how routinely collected data systematically recorded can provide new insights into important health outcomes such as breastfeeding.

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Is it time to review the idea of compliance with guidelines?

Professor Baker's questioning of the function and effectiveness of guidelines is timely.[1] In supporting his thrust towards guidelines that assist decisions, thereby influencing outcomes, I would like to add another consideration — that of effective medical education.

I recently completed the qualitative phase of a research project to determine if there are training behaviours on the part of GP trainers that affect the subsequent performance of the trained registrars in later practice.[2] Working GPs were asked about aspects of their training in practice that have had lasting value. One of the important findings concerned the manner in which trainers actively encourage and develop reflective practice.

A theme that came through from these interviews was that, like protocols, guidelines could sometimes suppress reflection, rather than encourage it. This arises when, as Baker says, guidelines are used to 'modify the clinical behaviour of practitioners and reduce inappropriate variations in care'.

Take, for example, the registrar who recounts a complex problem of a patient with asthma to his trainer when debriefing after morning surgery. The registrar is wondering about whether to prescribe a short course of steroids. If he is met by a response such as, 'what does it say in the guidelines?' (referring to the current, rather prescriptive and didactic variety), the overwhelming effect is that of compliance enforcement.

How different it would be if the learner were assisted through the process described by Baker, where guidelines present 'clear information about the management options available and the likely consequence of each', in a format that can be digested by doctor and patient in partnership. Such material supports reflective practice, rather than suppressing it, and can have a lasting effect on the learner's approaches to such problems, long after current management options have been outdated.

The new breed of guidelines envisaged by Baker would, in my opinion, help patient, practitioner, and learner.

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Do condoms actively prevent non-HIV STIs?

Matthews' and Fletcher's reminder of the importance of education in primary care about sexually transmitted infections (STIs) is timely.[1] Since its publication, further research has indicated that that not only HPV, but chlamydia also, is probably implicated in the development of cervical cancer.[2] The most recent figures from the PHLS also indicate the highest ever total of 2868 for new cases of HIV diagnosed in Britain in 2000 — a 7% rise on the previous year.

However, though the authors admit that although the impact of provision of free condoms in primary care is unclear at present, they nevertheless assume that such schemes actually support sexual health development. But is such an assumption evidence-based when considering the majority of non-HIV STIs?

Though there is good evidence that condom use reduces the incidence of both HIV infection and gonorrhoea,[3,4] HIV is one of the least infectious STIs transmissible by heterosexual vaginal intercourse. The risk of contracting HIV from a single episode of unprotected vaginal intercourse with an infected partner is only around 0.1%.[5] For more highly infectious diseases, the situation may be very different. The Medical Institute for Sexual Health in the USA concludes that 'condoms have not been proven effective in reducing the risk of HPV for females and the available data about transmission of genital herpes, syphilis, chancroid, hepatitis B, and trichomonas is insufficient to draw conclusions about effectiveness'[6].

Even these caveats assume a zero user-failure rate, yet among condom users up to one-third may not put the condom on before the start of penetration.[7] The method-failure rate has to be taken into account also. Furthermore Richens *et al*[8] have cogently postulated risk compensation as a mechanism whereby increased condom use may actually increase STI transmission rates overall.

These findings all cast considerable doubt on the effectiveness of condoms as the principle mode of non-HIV STI prevention. Many physicians in the USA are now advocating 'promoting abstinence or strict monogamy to help stop the spread of STIs'.[9] Even those who promote the use of condoms recognise their limitations and also acknowledge effective abstinence programmes as a 'valuable weapon' to confront the growing threat posed by the epidemic of STIs', including HIV. The public health and clinical significance of postponing adolescents' sexual onset cannot be overstated'[10]. It is high time that this was taken seriously by those involved in promoting sexual health initiatives in Britain,[11] including the RCGP.

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Sexually transmitted infections in primary care: a need for education

The ability to achieve and effectively deal with sexually transmitted conditions must

be based on appropriate training and clinical experience in all four areas of reproductive medicine: obstetrics, gynaecology, family planning, and genitourinary medicine (GUM).

All of these areas are an essential part of dealing with the day-to-day problems encountered in primary care.

The JCPTGP and the Royal College of Physicians supported the creation of a full-time senior house officer (SHO) post in GUM (subsequently GUM/AIDS) with comprehensively defined educational objectives, defined under the following headings: (a) sexual history; (b) examination; (c) investigation; (d) clinical skills; (e) management — outpatient/inpatient care, management — community aspects, management — interaction with other specialities, management — psychological/social; (f) education; (g) research.

The creation of this post in the early 1980s envisaged that such skills would be acquired by accepting clinical responsibility in the GUM Department, combined with working in the clinic under consultant supervision.

There would be formal and informal teaching as well as attendance at regional meetings. Opportunity for increasing clinical responsibility under direct supervision would be provided. Teaching and learning would be provided against an atmosphere of critical self-appraisal. Care of ward patients as well as outpatients would be included. Wherever possible, the trainee would be encouraged to gain experience of the difficulties of contact tracing and would be expected to accompany the contact tracer on domiciliary visits.

Matthews *et al* emphasise the importance and difficulty in sexual history taking. We also considered this to be a high priority. On completion of a six-month appointment the future GP would be expected to demonstrate his or her ability and confidence in undertaking detailed sexual history, understanding of the psychological and social pressures that may modify history taking, and an ability to relate history taking to knowledge of the epidemiology of sexually- transmitted diseases.

The job proved extremely popular and has enjoyed enthusiasm and support from the local Vocational Training Scheme for some 18 years. The outcome of almost two decades of commitment to VTS clinical training for future GPs has been compelling.

Many of our ex-SHOs are now principals in local general practices. This has profoundly altered the awareness, primary care diagnosis, and referral patterns of colleagues in general practice. The confidence shown by these ex-trainees rapidly disseminates within the practice and a very positive and supportive attitude emerges. The increased knowledge and awareness disseminates to other partners via a process of internal referral and informal discussion.

There is need for networking and increased communication and understanding between all health care professionals contributing to integrated provision of sexual health clinical services.

To achieve the improvements required with a National Strategy for Sexual Health the specialty must increasingly work in close collaboration with GPs. We would strongly recommend the creation of similar full-time SHO posts for vocational trainees in general practice.

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Ageing Britain

Ageing, as opposed to getting older, may not be inevitable (witness the advance of health care) but choices remain unavoidable.

Michael Drury and Julia Neuberger[1] confuse the laudable pursuit of 'ethical choices' with 'discrimination against older people', muddying the water still further with mention of the 'value' of persons — 'Nelson Mandela would have used up the greater part of his value while still a prisoner on Robben Island. Winston Churchill was well into his seventh decade before he became Prime Minister'.

By failing to give a clear definition of what they mean by 'ageism', yet declaring it to be as unacceptable as sexism or racism, they have fallen into the 'condon trap'. Aristotle showed that equity required that not only should like cases be treated equally, but unlike cases should be treated differently. It may at times be reasonable to discriminate between the sexes, especially so far as health care is concerned. For example, we should not offer maternity care to men. Similarly, we should target certain screening programmes at high-risk individuals on genetic grounds, e.g. screening for sickle-cell anaemia should be discriminatory towards African racial origins. The key ethical ground is the utilitarian commonplace that 'finite resources should be targeted where they will achieve most benefit'.

Seeming to reopen discussion — 'that does not necessarily mean treating older people in exactly the same way as younger' — they quickly close it again with 'It does mean equal respect and equal consideration; being, in other words, considered of equal value'.

The 'rescue question' puts our daily dilemmas into sharp and dramatic focus — would they seriously suggest that when all other considerations seem equal, the helicopter winchman should not put the 10-year-old in his harness before the 80-year-old?

Nelson would have pushed the child forward, as I hope would Winston and thankfully so would a goodly proportion of ordinary older people.

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Summative assessment

We read with interest the letter by McKinstry, Blaney and Moy [1]. The authors describe the current summative assessment format and express specific concern about multiple attempts at the MCQ component. They request that either the examination be altered or candidates limited in the number of attempts they make.

We would like to make the following points. First, in order to pass summative assessment overall, a candidate requires to pass each of the four components. When summative assessment was piloted in the West of Scotland no-one failed on the MCQ. Since the system became professionally led in 1996 there have been 44 registrars who have not passed the MCQ.

The authors correctly state that randomly guessing answers will on average give a score of 50%. However as the pass marks to date have been just under 70%, the chance of achieving a pass by random guessing would be extremely unlikely. In each exam the fail rate is around 4.5% and the distribution curve tails off considerably at this level.

The authors refer to 'reports of registrars' passing on their fifth attempt of the MCQ. While not condoning multiple attempts they should be taken in context. Since 1996, nine individuals have passed the MCQ on their fourth attempt and two on their fifth. This represents 11 individuals out of a total of 6803 who have passed the MCQ over the four-year period.

There is currently no limit to the number

of times the MCQ can be attempted. If the number of attempts were restricted a legal challenge from a candidate would be uncharted territory, as it has not been tested. However the summative assessment protocol states that if a registrar has sat and failed on two occasions there should be a discussion at Deanery level. It would seem prudent that another failure should involve the JCPTGP in considering further training and should involve wide consultation about the registrar. If the Deanery discussion advocated in the protocol involved an educational needs assessment, this would help ensure that, if a registrar does subsequently pass, their chance of passing has increased as a result of improved knowledge, and not randomly.

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McKinstry *et al* in their letter[1] express concern that the MCQ component of summative assessment can be attempted several times by GP registrars. Their fear, it seems, is that 'minimally competent' doctors may pass by merely resitting the paper.

My own concern with MCQs in medical examinations is that they ask for absolutes when very few exist in medicine. Take the title of McKinstry's letter: 'Can anyone pass the summative assessment MCQ?'. This in itself can be read in several ways. I, and I believe others, have passed the MCQ paper, so it is not beyond the capability of us all; however, my two-year-old nephew is unlikely to make a success of it. I would therefore cautiously answer this question: 'Don't know'. Indeed I remember my anatomy lecturer at medical school declaring that the correct answer to some MCQ questions is 'Don't know'.

Perhaps this is being a little mischievous but my point is: the fact a candidate may need to sit a paper more than once does not necessarily suggest he is a dreadful candidate seeking success through chance.

The truly incompetent GP registrar, I believe, will consistently fail the video component/simulated surgery.

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Evidence-based medicine

In spite of the growing demands for evidence based medicine, many of us in general practice are unable to back up our hunches with proof. One of the most common of all complaints is a cough and runny nose. I have a laboratory service for five days a week, but even so I am expected to advise at the time of the consultation if an antibiotic is indicated. Clinical findings are often absent. I now use my stock question; 'What's the colour of the sputum or the nasal discharge?' This used to be simple until I realised that there is a complete range from cream to deep sea-green, according to the interpretation of the individual patient. Standardisation came from the medical library in my consultation room. Significant yellow is that of Laurence and Bennett's *Clinical Pharmacology* (6th edition) and is awarded an antibiotic, as is the green of Brain's *Clinical Neurology* (5th edition). I suppose I will soon have to allow for the age of the textbooks and their fading colours. I often wonder what the authors of these well known tomes would think of their extra use. Perhaps one day we might get to the stage of new eponyms, such as 'Laurence yellow' and 'Brains green'.

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Demands for urgent care

Luthra and Marshall have made an interesting analysis of how practices cope with demands for urgent care.[1] In their discussion, they postulate how practices might improve on the systems they have based on their findings. However, in the United States, current thinking about access to care has moved on considerably[2] in the past few years and in the UK over the last year.

The most popular model described by the authors for providing urgent appointments on the day of request was a system of blocking out slots for urgent or same-day cases (61% used this method). This method is known as a 'first generation open access system'.[3] They suggest that this might be useful to other practices who want to consider how to deal with same-day requests. However, as receptionists would testify, this soon leads to a number of problems. First, there are the 'not quite urgent' appointments — patients who are difficult to classify (they can wait until tomorrow but no longer). Secondly, the creation of a black market in appointments — the phenomenon by which patients are told to ring the next morning for an appointment as there will be some released then. Thirdly, the morning rush hour of patients trying to book those newly released appointments. Finally, the difficulty in who judges the degree of urgency — the non-urgent patient booked into an urgent slot.

Many doctors in the US, and now in the UK, through the work of the National Primary Care Development Team,[4] are using a system known as advanced access. Developed by Murray,[3] this system offers a patient an appointment on the day that they would like it — no ifs or buts — and most appointments are on the same day. Demand is very predictable; for instance, if a doctor normally offered 20 appointments in a surgery then 90% of the time the demand would be between 16 and 25 patients. Also, long-term experience has shown that it does not lead to a rise in demand — counter-intuitively, it falls — this has been demonstrated time and again. There are a number of reasons for this, including:

- patients do not make appointments in three days' time in case they do not get better, and
- a shattering of the assertion that care is given by face to face contact.

With this model, patient satisfaction is greatly increased, however, so is that of the clinical and reception staff. Not only is there greater continuity of care, but patients with more difficult management problems can be cared for by their own doctor.

We assumed in the past that, by limiting capacity, demand will be limited. Demand is influenced by many other factors as well. Experience from practices that use advanced access find that doctors do not have to work late so often. The extra work is in bringing down the backlog of patients in the first place.

The next step forward is not, as the authors suggest, looking at the older appointment systems but thinking about how we can spread the techniques used in the primary care collaborative.

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Medical errors and adverse effects

On the assumption that knowing what something is helps to solve problems that arise with it, the article by Sheikh and Hurwitz fell short of the mark in defining medical errors and adverse effects. Box 1 indicates that an adverse event is an injury caused by medical management. Elsewhere in the article, an adverse event is defined as 'an event or omission arising during clinical care which causes physical or psychological injury'. In the former, the event has to be caused by medical management; in the latter, it does not — and, in fact, need not have a known cause. The implications for methods of detection are enormous; if a cause is known, a simple reporting system, such as discussed in the article, is sufficient. If a cause is unknown, as is likely to be the case for many adverse events, a reporting system is inappropriate. As post-marketing surveillance of medical technologies is unlikely to reveal the full magnitude of adverse events, a detection system requires a denominator as well as a counting of the events. For example, in what proportion of people is drug 'X' associated with a sign or symptom that may be heretofore unknown, in what types of people, and under what conditions?

Nothing short of ongoing monitoring (although it might possibly be by random sampling if done sufficiently widely) will answer these questions. If we are serious about detecting and learning from adverse events then routine medical records must reflect people's signs and symptoms, the interventions (e.g. medications) that they are subject to, as well as major sociodemographic characteristics and all diagnoses (to capture co-morbidity). Although this places a heavy burden on medical record keeping, computerised medical records systems should be designed to make this easier.

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Abdominal pain – bedside tricks?

Pain or discomfort in the right hypochondrium is a common finding in patients with abdominal pain. A thorough bedside examination can often give the diagnosis.

I am currently collecting data to write a short review on the clinical examination of the abdomen under the right costal arch. By studying the literature I have so far identified ten different signs that can be elicited in the examination of the right hypochondrium.

But there are probably a number of bedside tricks and signs that have never been desrcibed in the scientific journals. I am therefore interested in information from readers of the *Journal* who happen to use or know of clinical signs in the examination of the abdomen under the right costal arch that are not commonly known.

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Diagnosis and general practice

Summerton discusses the need and feasibility of a diagnostic research agenda in general practice.[1] The author outlines major issues about designs of diagnostic studies in primary care settings. According to our opinion the author omits some critical aspects in the diagnostic research agenda.

Often diagnostic research is about investigation in general practice, like laboratory tests and diagnostic imaging. But in general practice most problems are dealt with in the consultation room without further test ordering.[2] A major problem is that the relative value of prior knowledge of the patient, history taking, and clinical examination, and hence the value of the symtpom patterns in achieving an accurate diagnosis is not well known for many common complaints. Therefore, the value of basic clinical skills in the consultation room of general practitioners should be studied more thoroughly. These skills are cheap to perform and easy at hand.

We studied proficiency of basic clinical skills of graduates at four medical schools. We found that many basic clinical skills were not well performed and lead to inadequate processing of clinical information.[3] We also observed marked differences of proficiency between graduates and between groups of graduates of various medical schools.[4] Hence we conclude that graduates are not well 'skilled' when they leave nedical school. Further training of basic clinical skills may not remediate this problem because graduates are either trained in high tech hospitals or in general practice. In hospitals, basic clinical skills are often repleaced by technical investigations and this leaves graduates unable to train a large number of skills. When graduates are trained in the general practice setting, training may also be suboptimal. Evidence suggests that GPs do not perform very basic skills at a desired level.[5] It remians largely unkown how GPs correct for inadequate proficiency of basic clinical skills and this warrants valuable research.

We would especially like to draw attention to an important implication for the design of future diagnostic studies. Unsatisfactory use of basic clinical skills of GPs can lead to a considerable source of variance in diagnostic research studies. If skills are considered as a diagnostic tool in future studies, the execution of skills needs to be as uniform as possible and in studies this must be rigorously assessed. If this is omitted correct interpretation of the results will be difficult and sample sizes must be unnecessarily high to establish meaningful relationships between items of clinical information.

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