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Questions about COPD

The subeditor on my student paper would never let us end a headline with a question mark: the writer should be clear about what they are saying. Rupert Jones restates the question early in his leader on chronic obstructive pulmonary disease:[1] 'we need to know whether there are effective strategies to stop people with early disease progressing, and if so, how to detect the disease early'. Without providing convincing evidence he ends with what seems like an answer: 'early diagnosis and active management can make real differences to the millions suffering to breathe' but use of the word 'can' rather than 'does' veils continuing uncertainty. The list of pharmaceutical sponsors and commercial interests, creditably included, helps us to weigh his views appropriately. His 'advice for any individual with early airflow obstruction needs to be that they may be at higher risk, but not that they are at the start of a relentlessly progressive disease whose course can only be changed by stopping smoking'. Leader writers and doctors should be clear about what we are saying: people — especially those with airflow obstruction — should stop smoking.

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Early diagnosis of COPD

The article regarding early diagnosis of COPD[1] was of particular interest, as our practice has recently implemented a Structured Systematic Screening Programme for the Early Detection of COPD. Patients are identified by case finding in routine surgeries and in both current and ex-smokers, those calculated to be 'at-risk' (over 40 years, with history of 15-pack-years or greater)[2] are subsequently invited for spirometry with the specialist nurse practitioner. This also triggers smoking cessation advice if appropriate. After 10 months, 56% of the target population have their risk documented, and of those, 45% have undergone spirometry. Thirty-five per cent of patients on the current COPD register were diagnosed through this initiative; an increase of 54% on the register held at the start, supporting beliefs that COPD is grossly under-diagnosed and consequently under-treated.[3]

As a large and increasing cause of worldwide mortality and morbidity, COPD cannot be ignored. Actively targeting those at risk allows optimal management and specific health promotion for example, vaccination. Recent work also suggests that diagnosing early airways obstruction in asymptomatic smokers does increase cessation rates,[4] thus preventing disease progression, and fuelling the argument that initiatives such as this are indeed of great health and economic benefit, and should be more widely employed.

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Appropriate postgraduate training

It's not often that this unreconstructed Essex boy finds himself gazing wistfully north of the M25 but such was the effect of Elaine McNaughton's editorial[1] describing an innovative programme for GP speciality training in Angus. I couldn't help but contrast life as described in the East Deanery of Scotland with that we are presently experiencing in the Eastern Deanery of England.

McNaughton rightly stresses that a meaningful implementation of Modernising Medical Careers (MMC) demands training programmes that not only provide doctors specialising in general practice with the required competencies but also are attractive enough to encourage high calibre doctors into the speciality. The programme she describes attempts to meet these challenges and provides a useful model for elsewhere. The main problem with innovation is that you have to be able to implement it and, in our part of the UK, we are hitting something of a reality gap.

Course organisers in the Eastern Deanery have spent the past 3 years busily designing their schemes in preparation for MMC and very good some of them looked too. In late August we were informed that, contrary to repeated assurances, funding had not been obtained to support 18 months in practice-based training and we were asked to re-design our schemes to include 2 years in hospital posts. The Deanery is now involved in frantic negotiations with the Trusts to 'badge' sufficient hospital posts and with general practice being at the end of a long queue, it's difficult to be

confident that the posts obtained will necessarily be those with the highest relevance to our speciality. To add to this, we've also been informed that there will be no obligation for hospital-based trainees to attend their VTS educational programmes as the expectation is that their teaching will be provided within their specialist departments. Apparently this arrangement has the backing of the RCGP following their consultation with sister colleges.

We now have the frankly bewildering proposal that doctors specialising in general practice will receive the vast majority of their education and training delivered by colleagues in other specialities. Will such schemes be attractive to high calibre doctors? I very much doubt it. We might have to explain to prospective applicants that, as far as general practice training is concerned, 'fit for purpose' only makes sense if they accept that their purpose in life is to bide their time staffing hospitals.

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The good lie?

Dr Fitzpatrick wrote an interesting piece in the *BJGP* in Nov 2006,[1] making a good point about honesty being the best policy in the public health arena.

In the second part of his article, he then selectively quotes, twice, from a BHF spokesperson, Dr Mike Knapton. I could not see the source of Dr Fitzpatrick's complaints about Dr Knapton's remarks.

Firstly, in relation to a review article about eating oily fish and fish oils,[2] Dr Knapton is quoted as saying, 'people should not stop consuming omega 3 fats or eating oily fish as a result of this study'.

That seems precisely accurate to me. Dr Knapton doesn't seem to be saying that people should START consuming more of these items.

Secondly, in relation to an interventional study[3] that hoped to increase the exercise of young children and thus, produce a lower BMI, Dr Knapton is quoted as saying, 'we know it's crucial to encourage good exercise habits from an early age'.

I would point out that this DOES appear to be good support for this viewpoint — see for example this systematic review by Sallis *et al.*[4] Additionally, in Dr Fitzpatrick's original source for Dr Knapton's quotation,[5] there is the following remark, 'The British Heart Foundation, which part-funded the study, accepted the research was solid'.

I conclude that it is very easy to create a selective impression with quotations and evidence and that there is evidence that Dr Fitzpatrick may have fallen into the very trap about which he warns us.

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Competing interests

I am a friend of Dr Mike Knapton (and he can, in fact, fight his own battles!)

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Author's response

As any quotation is selective, the question is — did my selection of Dr Knapton's statements misrepresent him? I do not believe it did, he has not — to my knowledge — claimed that it did, and nor does Dr Thomas substantiate his implication that it did.

The quotations I used indicate that, in response to specific studies failing to confirm the health benefits of these interventions, Dr Knapton, in his capacity as health advisor to the British Heart Foundation, continues to promote the consumption of omega 3 fats and exercise among schoolchildren. I believe that this accurately represents Dr Knapton's position. It seems from Dr Thomas's letter that he agrees with Dr Knapton's position.

Both Dr Knapton and Dr Thomas are entitled to their prejudices, but my point is that there is no justification for foisting them on the public when they are not supported by scientific evidence.

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The support of obese patients in primary care

The Editorial and two articles[1,2,3] in the September issue of the Journal highlight the current difficulties in encouraging and supporting patients with obesity to reduce weight and maintain the achieved weight. One paper highlighted the effectiveness of a 'fourth level' of support, comparing it to other less supportive levels which were ineffective, but recorded only four out of 28 patients receiving this support.

'Fourth level' support had the characteristics:

- Non-judgemental and sensitive
- Direct and unambiguous
- Provision of personal information
- Provision of explanation and practical advice
- Provision of psychological support
- Group support.

The Thakur practice is an urban practice with a list size of approximately 3500. For the last 2 years patients with BMI >30 or BMI>27 with comorbidity have been offered during consultations with the GP or practice nurse or by publicity in the practice leaflet, free attendance at an