

findings from the ECLIPSE trial should enhance our ability to help women make the best choices about their health.

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nMRCGP exam

As I am now in my ST3 year and due to complete GP training next August, I am eligible to take my Clinical Skills Assessment (CSA). But when?

Having entered GP training at ST2, I completed 6 months in general practice and 6 months in an innovative post during my ST2 year. During ST3 I have 6 months of paediatrics, followed by 6 months of general practice. And there lies my dilemma.

I could sit the CSA in October or January/February, but at that time I'll be doing paediatrics. Although useful for my general practice career, not the best preparation for the CSA, as this will test a much wider area of practice.

Option 2 is to sit the CSA in May. I'll be back in general practice by this time so will have a chance to prepare properly for the assessment. However, results aren't published until June, just 2 months before I complete my training. I would therefore be applying for jobs without having completed my nMRCGP — would I even be eligible for short-listing? And if I don't pass ... My training programme complete but no nMRCGP. With the expense and time involved in taking the

CSA, I don't want to just 'give it a go' in January without feeling properly prepared.

I am aware that other deaneries schedule the whole of ST3 in general practice, allowing trainees to choose from all three sittings of the CSA. Perhaps a sitting in mid-March for those of us doing a more restrictive training programme?

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Diabetes prevention

With the publication of several large randomised controlled lifestyle change trials showing benefit in delaying or preventing progression from pre-diabetes to type 2 diabetes, work has been taking place in many locations to translate research evidence into practical interventions to improve the care of our patients at the primary care level.

Laatikainen and colleagues are to be congratulated in conducting the large Diabetes Prevention Project in Australia.¹ Like us, they successfully delivered a structured programme to patients with pre-diabetes using group work, delivering education enhanced by motivational techniques. Our programme was a randomised controlled pilot study testing two different dietary interventions.² They recruited a larger number of pre-diabetic participants and was able to show a statistically significant effect in reducing progression to type 2 diabetes compared with baseline using an audit methodology.

The biggest obstacle faced by many working in this field, including ourselves, is to secure adequate funding to develop and refine such pragmatic intervention programmes. This work is vital to the wellbeing of our patients. Up to 90% of people who develop diabetes may not have done so had their lifestyle choices been different, and interventions have

been shown to make a real difference.³ We congratulate our Australian colleagues on their excellent work and are also envious of the opportunities that they have for substantial translational research funding.

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In response to the article entitled 'Can type 2 diabetes be prevented in UK general practice?' published in the August issue of the *BJGP*,¹ we would like to highlight our experience with diabetes prevention.

In the Finnish Diabetes Prevention Study,² participants who successfully achieved their lifestyle-change goals for physical activity and diet did not go on to develop diabetes after 7 years of follow-up.³ To determine whether the results of clinical trials could be reproduced in the 'real world' of primary care, the GOAL Lifestyle Implementation Trial to prevent Type 2 diabetes in primary health care,⁴ a trial using a structured programme was designed and trialled in Finland.

In 2004–2006, a sister project of GOAL was run in the Greater Green Triangle region of South Australia: the Greater Green Triangle Diabetes Prevention Programme (GGT DPP). This study evaluated the feasibility of a structured group programme for lifestyle modification in Australian primary healthcare settings