publication in fact shows the endpoint correctly at 9 weeks. The error appears to have occurred during the production phase at the journal and was not spotted by me in the final proof. I apologise and take full responsibility for this. However, this does not alter the fact that the Roland Morris Disability Questionnaire (RMDQ) scores in Meng *et al*'s study of people with chronic back pain did not improve significantly during the course of their study.

For Froud and Underwood to obtain the data that they present in Figure 1 overleaf they have had to re-interpret results from their own study³ and contact the author of another⁴ to present previously unpublished information. The main thrust of our article is that usual care should be adequately described in any published paper so that the average reader can understand how the study participants and their own patients compare. It should not be necessary to have to make further enquiries.

Given this, I am grateful to Froud and Underwood for the data that they have already supplied to us. This new information adds to our understanding of the course of chronic back pain. While agreeing that their new data show a trend for chronic back pain sufferers in their study to improve over time, I would beg to differ, however, with their conclusion that it 'more closely mimics the acute/sub-acute trajectories'. The information about the UK BEAM study³ that they sent to me after the publication of our article gave RMDQ scores for patients with acute, mixed, and chronic duration of back pain. From this I calculate the following falls in RMDQ scores at 3, 6, and 12 months respectively: acute (1.66, 1.3, 0.26), mixed (1.45, 0.94, 0.66), and chronic (1.31, 0.7, 0.91). This would seem to back up our conclusion that 'the longer the duration of the pain, the slower the rate of improvement,' certainly in the first 6 months. The falls in RMDQ score between 6 and 12 months are less than one point which is unlikely to be clinically significant. Data obtained from Licciardone *et al* by Froud and

Underwood show that RMDQ scores of patients with chronic back pain fell by only by 1.1 in 24 weeks, which the original authors described as showing 'no significant decrease'.⁴ The overall picture remains that the outlook for patients with chronic back pain is less favourable than those with more acute onset.

Despite these very valid points, the overwhelming message that arose from our review remains true. The content and outcome of usual care of low back pain in primary care is not well described and is quite variable. This has implications for research when usual care is employed as a control, but also when considering how to bring evidence-based medicine into routine primary care.

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Authorship of editorials

The February 2009 issue of the *British Journal of General Practice* provides some interesting tensions that reflect the insecurities that Donald Berwick alludes to in the John Hunt lecture 2008.¹ The *RCGP News* for February 2009² rightly has as its headline that academic general practice is the 'best in the world', that primary care researchers have performed outstandingly. In the

journal itself are three articles on depression and primary care, and an editorial on the same topic. The editorial,³ written by academic psychiatrists, reviews the three articles, and then provides an opinion about what primary care clinicians should be doing in the consultation: 'Managing depression in primary care: it's not only what you do, it's the way that you do it' is the helpful title.

The question that I ask myself is why do we need to have an editorial from academic psychiatrists, when we know that academic general practice is so strong? We are fortunate to have at least six Professors of General Practice in England, who have built their careers based on research into common mental health conditions, who are more than qualified to have penned the editorial. Is it a feeling, a sense, that general practice needs the specialist view to endorse the findings from primary care? That without this endorsement, and acknowledgement, the findings are in some way diminished? The reverse is true. Academic medicine is not the same as day-to-day clinical care, and psychiatry is not the same as general practice. We do not need the endorsement of psychiatrists to either review the findings, or to give us their opinion on how we should consult. We should be acknowledging that we do manage people with common mental health problems in primary care, very frequently without the benefit of specialist services, and that this care is some of the best in the world.

If we are to understand the meaning and implications of the articles on managing depression in primary care, then asking an academic psychiatrist is as relevant as asking an academic ENT surgeon how to manage children with acute otitis media. In both cases, it is the GP who has the most experience and knowledge of the topic, not the specialist. The ENT surgeon rarely sees children with acute otitis media, and psychiatrists rarely see people with depression and anxiety who are managed in primary care.

We should be celebrating the high standard of general practice, and the international standing of our Professors by seeking their views of the three articles, not by asking senior lecturers in psychiatry.

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Competing interests

I share a hot desk with Dr Boardman — my comments are not directed in any way personally to the authors concerned. I have disagreed with the Professors of General Practice on several occasions, and will continue to do so!

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Editor's comment

I invited Jed Boardman to write this editorial as he seemed well placed to draw the results of the other papers together, and to put them into a wider context. I felt the piece that we published justified my confidence in him (and I note that Alan Cohen has not taken issue with the content). We have long left behind the idea that all our learning came from specialists, and almost all the editorials we publish are written by primary care doctors and researchers. While it would reveal insecurity to feel we should only ever

listen to specialists, it would reveal just as much if we refused ever to listen to them. Inviting a specialist to comment is a sign of willingness to be open and learn from others, not of insecurity.

David Jewell

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Defending the GP clinician–researcher

Good on you for defending the GP clinician–researcher!¹

Actually we're not quite extinct. My first clinical paper was in the *BMJ* in 1994 and was about patients with problem drug use both in my own practice and that of a local colleague — and there have been other publications since about various things (recognition of depression, an RCT of a baby illness scoring guideline). I've also done quite a lot of unpublished pilot work in my own practice for larger studies — mainly asking my patients for advice on how to make study designs more acceptable.

One problem we have in the UK is that it has become incredibly onerous to get past the ethics and research governance hurdles; understanding the system has now become the exclusive domain of the professional researcher. In that respect, the species 'amateur researcher' is now dead.

The increasing tendency to work in teams is no bad thing. Pretty much all my published work has benefited from some sort of expert input (mainly involving statistical and qualitative advice). We still

need to have primary care clinicians who can ask research questions though. I think that my expert research colleagues would generally say that working with a clinician has helped them to achieve change in the way that practitioners work with individuals in a way that research primarily designed to influence policy can never do. As you rightly point out, most primary care research is no longer based in general practice but is about general practice or is based in secondary care and is hosted in general practice. This tendency will lead inevitably to the relegation of general practice researchers to the status of 'second rate players in a second hand game'.

Incidentally, I think that you have somewhat over-interpreted the data in your table.¹ Quite a lot of us have both clinical and academic appointments (in my case the time allocation is 60% clinical work and 40% research) and we tend to just put our academic appointments in the author details for the *BJGP*. Otherwise our heads of university departments get annoyed. Our practice colleagues are, unfortunately, not usually particularly impressed by our getting published in academic journals and so we tend not to bother pushing for inclusion of both our job titles in the Journal!

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