with particulars',⁴ which can only come from practice-based research.

John Campbell Murdoch,

Professor, School of Primary, Aboriginal and Rural, Health Care, Rural Clinical School, St John of God Medical Centre, PO Box 412, Bunbury WA 6230, Australia.
E-mail: Campbell.murdoch@uwa.edu.au

REFERENCES

1. Murdoch JC. The end of practice-based research? *Br J Gen Pract* 2009; **59**(558): 52.
2. Tudor Hart J. Clinical research by GPs in their own practices. *Br J Gen Pract* 2009; **59**(560): 214–215.
3. Mathers N, Howe A, Field S. Clinical research by GPs in their own practices. *Br J Gen Pract* 2009; **59**(561): 296–297.
4. McWhinney IR. 'An acquaintance with particulars...' *Fam Med* 1989; **21**(4): 296–298.

DOI: 10.3399/bjgp09X421012

Medical waste

With the Chancellor's budget having been recently announced amidst the ongoing global economic downturn, I thought it an opportune moment to highlight to readers the current situation of pharmaceutical wastage in the NHS. Currently undergoing a placement in public health I was privy to witness one of many 'spot inspections' of a vehicle that was in-transit to the local waste disposal site having collected all discarded medications from a local pharmacy. The contents of the van were astounding. Inside were over 30 plastic sacs containing stacks of unopened blister packs, boxes of unused laxatives, and endless tubs of emollients, most of which were well within their expiry date. In addition, there were over a dozen large plastic tubs full of a certain well-recognised and quite pricey supplement drink, all of which had been unused and subsequently thrown out. At present, the current cost of medicines wastage in the West Midlands stands at an impressive £32 million every year,¹ while back in 2006 it was estimated that the cost of returned and unused medicines in total throughout the UK was anything up to £75 million per year.² Despite these huge figures it would appear that at grassroots level the problem remains largely unchecked and

obviously some additional intervention is required in order to reduce this unnecessary and costly drain on our health service. Although the responsibility lies with all healthcare professionals it does appear a large source of wasted medicines, using that inspection as a basis, comes especially from local care homes. Due to the apparent failures in communication that are occurring, the current approach of allowing endless piles of unwanted medicines to accumulate, gather dust, and then be disregarded at the end of the month seems an unforgivable and unsustainable way to manage the problem.

With the current economic climate, as well as ever-increasing demands on ever-tightening NHS budgets, it would seem prudent to emphasise that efficient medication reviews by GPs, pharmacists, and non-medical prescribers could at least, on our parts, help stem this ruinous haemorrhage of funds from our local PCTs.

James Crossingham,

GP ST1 trainee, Public Health, Jubilee House, Walsall.
Email: james.crossingham@walsall.nhs.uk

REFERENCES

1. West Midlands NHS. Medicines Waste Campaign Page. <http://www.medicinewaste-westmidlands.com/wmpages/wmcontact.html> (accessed 15 May 2009).
2. British Pharmaceutical Conference. Britain's £75million drug waste. [News] <http://www.rpsgb.org.uk/pdfs/pr060904-6095.pdf> (accessed 15 May 2009).

DOI: 10.3399/bjgp09X421021

Osteoporosis guideline

Jonathan Bayly is correct in reminding us that the guidance from the National Osteoporosis Guidelines Group (NOGG) should be critically appraised.¹ It is not however, a rival to NICE but seeks to provide a user-friendly guideline to include men, steroid-induced osteoporosis, the newer bisphosphonates, recombinant human parathyroid hormone, and also to include the World Health Organisation Fracture Risk Assessment Tool (FRAXTM).

Since NOGG is web-based it is relatively easy to keep it constantly updated.

Guidelines are dependant upon published studies. These studies, which are expensive, at present recruit patients that are at very high risk of developing the endpoint in question, but are otherwise relatively uncomplicated. The studies are comparatively short and are not powered to study the long-term side effects.

These relatively short-term controlled studies are then extrapolated to the real world of free roaming patients, with comorbidities, co-prescribing with its associated drug interactions, and poor medication compliance. These patients may also be in a different age range to those in the randomised controlled studies. Further studies are required after the pivotal randomised controlled studies and granting of a product licence, to study medications in the true environments in which they are used.

However, because we do not have the best data this must not be an excuse to do nothing. 'The care gap is wide and not getting any narrower.'¹ We now have the opportunity with a user-friendly tool, to focus on the end organ damage of fracture remembering that osteoporosis is a very important risk factor, but nevertheless, only a surrogate marker.

Alun Cooper,

Bridge Medical Centre, Wassand Close, Three Bridges Road, Crawley RH10 1LL.
Email: alun.cooper@gp-H82047.nhs.uk

Conflict of interest

I am a member of NOGG-the National Osteoporosis Guideline Group.

REFERENCE

1. Bayly J. A fractured service: will NOGG mend it? *Br J Gen Pract* 2009; **59**(562): 371.

DOI: 10.3399/bjgp09X421030

CAM

I would be interested to hear Edzard Ernst's observations on Fiona Barlow and George Lewith's 'The Ethics of Complementary Therapy Research

Recruitment — a case study'.¹ It is the attitude described here that is fired by Ernst's crusading approach to criticism of CAM, and this must influence those without knowledge or experience of integrated medicine. Fortunately, most medics will have searching minds.

Perhaps Ernst could comment in his, what appears to be a regular slot in the *BJGP* (well done to the Editor)? Should this contribution from the Peninsular Medical School be called 'Letter from (Almost!) America?'.

I really admired his efforts to find a clutch, of what he considered, dodgy websites of Homeopathic Organisations.² I agree with his comments on the contents as would any homeopathically trained doctor, I'm sure. But it is a pity he did not balance that with an appraisal of reputable Homeopathic Medicine websites, such as our own Faculty of Homeopathy (<http://www.trusthomeopathy.org/>).

Graham Jagger,

GP and Undergraduate Teacher, Castle Street Surgery, Salisbury SP1 3SP

E-mail: graham.jagger@ntlworld.com

REFERENCES

1. Barlow F, Lewith G. The ethics of complementary therapy research recruitment: a case study. *Br J Gen Pract* 2009; **59**(551): 302–303.
2. Ernst E. Advice issued by professional homeopathic associations: a survey of websites. *Br J Gen Pract* 2009; **59**(559): 142–143.

DOI: 10.3399/bjgp09X421049

Author's response

Graham Jagger wants me to tell the *BJGP* what I think about the Barlow/Lewith article.¹ As in all areas of healthcare, clinical trials rely on the cooperation of clinicians. If they refuse to help with patient recruitment, trials may not be feasible. If I had been such a clinician in Southampton, I probably would have told my patients what the evidence on spiritual healing is. My own review concluded in 2003 that 'the weight of the evidence [is] against the notion that distant healing is more than a placebo'.² Since then the most rigorous studies continued to be negative. My point is that a clinical trial

needs a sound basis, and for spiritual healing I fail to see it.

Edzard Ernst,

Professor, Universities of Exeter and Plymouth, Peninsula Medical School, Complementary Medicine, 25 Victoria Park Road, Exeter EX2 4NT.

E-mail: Edzard.Ernst@pms.ac.uk

REFERENCES

1. Barlow F, Lewith G. The ethics of complementary therapy research recruitment: a case study. *Br J Gen Pract* 2009; **59**(551): 302–303.
2. Ernst E. Distant healing — an 'update' of a systematic review. *Wien Klin Wochenschr* 2003; **115**(7–8): 241–245.

DOI: 10.3399/bjgp09X421058

Editor's comment

Ho hum. The principle is to judge everything we receive on its own merits. We try to do that for the material on CAM, but it is made more tricky because of the generally well entrenched positions of authors, on both sides, and in addition it's not clear whether or not CAM is a core part of primary care. Edzard Ernst does contribute quite regularly, but it would be as wrong to reject any of his articles because of that, as it would be to accept anyone else's because their contributions are infrequent. — *Ed*

Mega-aggregation

In Italy, the government is trying to convince GPs to sign a new contract with many new duties but with not much financial reward. They are also being asked to consider the birth of new mega-aggregations of professionals and practices covering a large extension of the population.

At the same time, the government is considering shifting many services from secondary to primary care.

The reaction from GPs' associations is cautious or negative, seeing this as a disruption of trusts' power in microgroups, as a problem for patients obliged to walk or travel long distances to large buildings

where they will have long waiting lists, see many doctors, and end up with a duplication of examinations.

The government's indication is similar to the proposal of 'GP-led health centres' in the UK.

So, it is very interesting to read the paper by Morgan and Beerstecker indicating that there is no evidence to suggest that very large practices could provide or are providing more volume or diversity than the current average UK practice.¹

Therefore, a policy to create larger practices may not automatically lead to a transfer of work from secondary to primary care. This is because there is not an upper threshold above which practice size creates spare capacity and expertise to deliver a significantly greater volume of more diversity of extra services.

These data are very important and to be considered when we see, at the moment, plural inputs by national governments, for new 'governances' for family medicine,² coming bottom-down, not agreed by primary care,³ by secondary care, or by patients themselves (data for disagreement by Italian national statistic questionnaire where the GP–patient relationship is still seen as the 'must'), but dangerously pushed by the politicians because of their supposed economic interests, or others not considering what family medicine was, is, and will be (see a European Definition).

Francesco Carelli,

Professor Family Medicine, University of Milan, EURACT Council Director of Communications. E-mail: carfra@tin.it

REFERENCES

1. CL Morgan, HJ Beerstecker. Practice size and service provision in primary care: an observational study. *Br J Gen Pract* 2009; **59**(560): 186–190.
2. Department of Health. Implementing care closer to home: convenient quality care for patients. Part 1: Introduction and overview. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074428 (accessed 11 May 2009)
3. Union Medici Italiani. Reaction to pre-agreement on a new contract with mega-aggregations. <http://www.unionemedici.it/it/default.asp> (accessed 11 May 2009).

DOI: 10.3399/bjgp09X421067