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DOI: 10.3399/bjgp11X556317

Junior response to the global health editorial

As trainees and new GPs, we warmly welcome *BJGP*'s new International Advisory Board and plans to increase its emphasis on the international perspective of primary care.¹ We also read with interest the editorial highlighting the role that primary health care can play in the field of global health.² This comes at a moment when the need for undergraduate and postgraduate education in global health is increasingly recognised, such as by the recent *Lancet* Commission on the education of health professionals for the 21st century³ and *BMJ*'s editorial on training programmes in global health.⁴ The extent of the political capital given to this issue was highlighted at the House of Lords on 20 December 2010,⁵ when a debate led by Lord Crisp challenged the government on how they will ensure that the subject of global health is included in the education of all health professionals.

Benefits of gaining an international perspective on health care are manifold; offering personal and professional learning opportunities for those involved. There are also benefits to be gained by the NHS as a whole, as emphasised in the Department

of Health's framework for NHS involvement in international development.⁶ The importance of the UK contribution to global health has been highlighted in various other documents including the Crisp Report,⁷ *Health is Global*,⁸ the Tooke Report,⁹ and the *Gold Guide*.¹⁰

Some work is already underway; the UK medical student group MedSIN has produced a consultation document, based on the GMC's *Tomorrows Doctors*, that drafts specific global health learning outcomes for undergraduates.¹¹ The Alma Mata Global Health Graduates' Network¹² has also developed a proposal for postgraduate training in global health, due to be published in *Clinical Medicine* later this year. In general practice there is a rapidly expanding WONCA worldwide network of trainee and new GPs through the Vasco da Gama (Europe), Rajakumar (Asia-Pacific), and Waynakay (Ibero-America) Movements, as well as an increasing number of AITs and First5 GPs expressing an interest in international primary care through the RCGP Junior International Committee. Furthermore, a nascent group linking juniors involved in global health at the various UK Royal Colleges is gathering momentum. However, these efforts will need high-level support in order to effect change in an educational system that has not kept pace with the challenges of the 21st century.

The World Health Report of 2008¹³ underlined the importance of primary health care; 'now more than ever', and reminded us of the 1978 Alma Ata¹⁴ declaration. This recent surge of activity confirms a consensus that health professionals in the UK are not being adequately prepared for current and future global health challenges. As Lord Crisp highlighted, there is a lot of interest and agreement on this issue, 'what we need now is some action'.¹⁵

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DOI: 10.3399/bjgp11X556326

Experiences of academic GP specialty trainees

We were very interested to read the article by Rees and Stephenson on the future of medical education in the UK.¹ We are two academic GP specialty trainee 4s (ST4) who are enthusiastic about raising the profile of research and education in primary care. Academic ST4 training consists of a year attached to an academic department, and time is split equally between clinical practice and academic work. We also meet monthly for a training half day with the other GP ST4 trainees. This post is giving us the opportunity to refine our clinical general practice while developing further skills in teaching and research.

We are currently teaching third year medical students about the particular challenges of general practice consulting through using small group role play, and have also been involved in formative objective structured clinical examination assessments. In addition, we have completed an introductory course on teaching in primary care. We are finding this experience enjoyable and rewarding.

The guidance of experienced educationalists has given us confidence in negotiating the transition from learner to teacher.

Our research activities are based around ongoing trials in which we are learning to analyse data and present our findings at the Society for Academic Primary Care. We will also be involved in updating a systematic review and organising a pilot study with supervision from GP researchers in the department. A supported introduction to research is an ideal way to make this area more accessible to GP trainees.

Working in an academic department at an early stage in our training is a unique opportunity to forge long-lasting links with educators and researchers. We hope we can carry this experience forward into our future careers. Inspiring academic interest among young GPs through dedicated foundation year 2 and ST4 positions is crucial to raising the profile of teaching and research within primary care. The Walport report² emphasises the importance of integrated academic training. There are currently only 10 academic GP ST4 posts available in London. We very much hope that in the future there will be wider opportunity for GP trainees to participate in academia and benefit from similar career-enriching experiences.

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DOI: 10.3399/bjgp11X556335

Chronic daily headache

Simpson *et al*'s splendid evaluation of direct access concluded that direct access computerised tomography (CT) is now the preferred choice for patients with chronic daily headache in primary care.¹ They decided this after a rigorous identification of abnormal findings in the study, plus an economic analysis comparing CT scanning with other investigative options. We believe there is a third option — of no investigation and no referral.

The first reason for our view is given in the paper itself. Sixty scans (1.4%) from 4404 yielded a probable cause of the headache. A further 401 (9.1%) had incidental abnormalities. Of the 60 with abnormalities likely to be causative of the headache, four meningiomas, two metastases, two pituitary tumours, and two colloid cysts were resected: four other lesions led to surgery. We do not know if any of these patients had their symptoms improved, or even if the abnormalities actually were the cause of the symptoms. Their Table 3¹ shows a higher rate of imaging abnormalities in an asymptomatic population than in the headache population (albeit using magnetic resonance imaging, that is more sensitive) making it very likely that some of the abnormalities were not relevant.

What the authors omit from their deliberations is the clinical cost of CT scanning. One in 8100 women aged 40 will develop cancer from a single CT brain scan, with some forms of CT scanning posing a one in 80 risk of causing a cancer.^{2–3} These figures surely tip the balance. We know that many patients suffering chronic headache request CT scanning for reassurance.⁴ We also know a negative scan does reduce requests for medical care.⁵ However, the 'cost' may be too high. We GPs need to be honest in advising the patient that over 300 scans will have to be done for one patient to have a treatable abnormality — with no guarantee of therapeutic success — and that 27 (9% of 300) incidental abnormalities will be found in these 300