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## 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.<sup>1</sup> 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 report<sup>2</sup> 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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## 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.<sup>1</sup> 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 3<sup>1</sup> 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.<sup>2–3</sup> These figures surely tip the balance. We know that many patients suffering chronic headache request CT scanning for reassurance.<sup>4</sup> We also know a negative scan does reduce requests for medical care.<sup>5</sup> 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

scans. Finally for every 15 treatable tumours that are found, one new cancer will be caused (8/4404 divided by 1/8100). Scan, anyone?

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## Managing respiratory tract infections

Last year, as a previously completely fit and healthy GP of 32, I developed a sore throat, cough, and fever. Nothing so unusual about that and being fully aware of the NICE guidelines on prescribing in respiratory tract infections it did not cross my mind to see a doctor or self-medicate with antibiotics.<sup>2</sup> My Centor score of two would have suggested I would be unlikely to benefit. For me, as I suspect for many GPs of my generation, being a relatively low prescriber of antibiotics was a badge of honour and I knew the chance of serious complications was low.

Within 48 hours I had become increasingly unwell with a high fever despite regular antipyretics. I was vomiting and so weak I could not get out of bed. My sensible (non-medical) husband took me to the out-of-hours GP

and I was admitted. I had a temperature of 41.7°C, pulse of 120, and blood pressure of 80/60. My C-reactive protein was 450 mg/l and I was acidotic. I was diagnosed with pneumonia and treated with intravenous antibiotics. I was separated from my breast-fed baby who was not allowed to see me for 4 days. Blood cultures grew a Group A *streptococcus* and when, a week later, I still had a temperature of 39°C on paracetamol, a CT scan showed an empyema. A chest drain provided some relief but when my temperature remained high and a repeat CT scan showed that the empyema had not resolved I was transferred to a tertiary hospital for a thoracotomy. Complications meant a blood transfusion and an unplanned post-operative ITU admission. My husband was called to the intensive care unit urgently and drove to the hospital thinking he was going to be a widower. I spent a month in hospital and had 3 months off work. I was left with a hoarse voice that required months of speech therapy. It took time for me to rebuild my relationship with my son, when I first came out of hospital he would cry if he was left alone with me.

Would an early course of penicillin have halted the Group A *streptococcus* in its tracks? I have no way of knowing. I do, however, strongly agree with Stanton *et al* that research into identifying patients likely to benefit from antibiotics is an urgent priority. Although rare, complication of respiratory tract infections can be devastating.

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## Work, fit notes, and occupational health

Further to the article in October 2010 *BJGP*,<sup>1</sup> on the issue of fit notes, I would just like to point out the fact that it is not just GPs who are involved in the issuing of fit notes for patients. Your article appears to make this assumption. Accepting that GPs do not fully understand the working environment of patients, I do not believe we are the only group of clinicians that this is true of. If we are being true to the guidance sent out by both the Department of Work and Pensions (DWP), which was reiterated when fit notes were brought on line in April last year, supported by the Department of Health Cabinet Office document several years ago which also talked about the issuing of sick notes, that the responsibility of the provision of this document lies with the person who has clinical responsibility. That means a number of our secondary and tertiary care colleagues are responsible for that element of a patient's health that prevents them from attending work. I am, therefore, surprised that this is not mentioned at all, and your article basically says that it is all down to the GP. I don't believe it is and the article does not help in changing the culture that we are in and the ability to implement the DWP guidance.

In Bury we have worked hard to ensure that the appropriate clinicians involved are responsible for provision of the fit note and provide the appropriate documentation, however, it is still a struggle and I believe articles like the one that has been written actually gloss over the fact the other clinicians are involved.

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