

## LETTERS

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**Note to authors of letters:** Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

### Nutrition training in primary care

Sir,

Primary care dieticians in Dorset provide practice-based nutrition training for all members of the primary health care team (PHCT). This has been shown to be successful in significantly improving their knowledge of nutrition.<sup>1</sup>

Dietary advice is now an integral part of patient consultations in primary care. However, members of the PCHT may lack the knowledge and skills necessary to deliver accurate and consistent advice.<sup>2</sup> In most cases, additional training is required,<sup>3</sup> and the primary care dietician is ideally placed to provide this.

In Dorset, eight one-hour training sessions are provided to the PCHT on a range of nutrition topics. These include dietary counselling skills, healthy eating, and diabetes, as well as coronary heart disease.

Baseline nutrition knowledge and a subjective measure of confidence is assessed by questionnaire before and after training. To date, 28 out of 30 practices that have completed training have demonstrated a significant increase in knowledge. The majority also felt more confident when giving dietary advice, which is vital in order that patients do not doubt the staff's competence.

The training is offered to all staff, but mainly practice nurses (PNs) attend. Even though it is usually the PN who offers dietary advice to patients, we would like to encourage GPs to attend nutrition training. Owing to GPs' credibility as a source of information, reinforcement of the PN's dietary advice could help to make certain that it is followed. Full PCHT nutrition training would also help to ensure that all the dietary advice patients receive is consistent and up to date.

Anyone interested in finding out more about this nutrition training is welcome to contact the primary care dieticians in Dorset.

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### Accuracy of citations

Sir,

At a time when the *British Journal of General Practice (BJGP)* embraces change, you confirm your commitment to rigorous scientific research and your intent to strive for improved quality, presentation, and relevance.<sup>1</sup> In your Information for Authors and Readers,<sup>2</sup> I note that you send papers to at least two assessors, who may be GPs or other experts in the subject.

The peer-review process is described in detail in a statement made by the editorial board;<sup>3</sup> however, there is no mention of appraising the use made of the relevant literature. I think it essential that the *BJGP* should examine its current system of review to ensure that papers submitted for publication are adequately appraised, and that the reviewers take account of the use made of the current relevant literature. An effective mechanism must be developed for checking the accuracy of citations.

As I am a GP interested in the care of people with epilepsy, and do sessional work in a specialist epilepsy unit, I read with interest a paper on the audit of general practice records examining the process of care for people with epilepsy (October *Journal*).<sup>4</sup> On examining the references, I found examples of citation inaccuracy in references 2, 8, 10, and 28. Reference 2 gave a page range of 93-103

instead of 91-103; reference 8 is not as stated, and I have been unable to trace it; reference 10 gives the publication date as 1980 rather than 1986; and reference 28 states the volume as being 105 when it is actually 305.

There was also evidence of misquotation. The statement 'a general practitioner can expect to have 10 patients with active epilepsy' is attributed to reference 2, although the original document states, 'an average general practitioner will care for about 10 patients on active treatment for epilepsy', which is obviously not the same. Reference 4 is quoted as saying, 'epilepsy is a condition best cared for by the GP in the majority of cases', when the original states that people with epilepsy 'would normally continue to be cared for by the GP'. Reference 12 is said to recommend the development of a district-based epilepsy service, when, in fact, this is made by reference 11. Reference 12 was an audit published in a non-peer-reviewed journal; other, more critically evaluated audits could have been cited. The comment 'record keeping in general practice is often poor' is attributed to both reference 12 and reference 16. Reference 28 was unconnected to the text, as it examines different methods of taking an antenatal history and does not, at any stage, discuss the development of guidelines.

The authors list 30 references, which they quote on 46 occasions. The above illustrates some, but not all, of the instances of misquotation and bias by these authors, who conclude their article with the appeal for 'rigorously developed and evidence-linked' guidelines.<sup>4</sup> Appropriate use of the literature throughout an article is very important. For the new-look *BJGP* to achieve the ideal of scientific rigour, it will be essential to select reviewers who are familiar with the relevant specialist literature.

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## Authors' reply

Sir,

We have read with interest the criticisms of the referencing in our paper, 'A general practice records audit of the process of care for people with epilepsy'<sup>1</sup> made by your correspondent. While she rightly notes some errors, we would take issue with a number of the criticisms made.

We accept that there were typographical errors in references 2, 8, 10, and 28, which were not picked up at the proofs stage. However, three of these were not significant enough to prevent readers from tracking the references, though the fourth, we accept, was more problematic. The author is correct to point out that the recommendation for a district-based service was made in reference 11, and not 12 as stated. Reference 28 was incorrectly identified from the electronic database and this was not picked up at the checking stage.

The author of the letter states that there was evidence of misquotation in our paper; however, none of the examples given were used as direct quotes from the papers cited. For example, she argues that reference 4 was misquoted because it states that people with epilepsy 'would normally continue to be cared for by the GP', and we write that it states they would 'best' be cared for in this way. Since the statement in reference 4 was a recommendation of the Working Group, we do not consider it an unreasonable interpretation on our part that the Group believes this to be the *best* way of delivering care. In referencing article 16 as providing evidence of poor record-keeping in general practice, we accept that the authors of that paper note this may largely be due to the failure of hospitals to pass on information to GPs, and we ourselves make no judgement about the cause of poor record-keeping. In our view, these examples of 'misquotation' are issues of semantics and personal opinion. The author appears, to us, guilty of picking out individual sentences from

articles and quoting them with as much bias as we are accused of — and this clearly highlights the extent to which the conclusions drawn rest essentially upon any one individual's interpretation of the evidence.

The author argues that we could have cited 'other, more critically evaluated audits'. Of course, there are always other papers that could be cited, and every author, outside a systematic review, has to decide which references to include and which to exclude. It seems to us that there is some confusion here about the task of reporting a piece of research compared with a systematic review — our article was the former and made no attempt to be the latter.

Finally, we wish to record that we are happy with the peer-review process operated by the *BJGP* and found the referees' comments both useful and constructive.

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## Reference

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## General practice — a postmodern specialty?

Sir,

It was unfortunate that Mathers and Rowland used the term 'scientific rationalism', as if scientific ideas are somehow not compatible with 'postmodernism', in their article, 'General practice — a postmodern specialty?' (*March Journal*). The rigid, doctrinaire hospital-based approach which opens their discussion is neither scientific nor rational. The hypothetico-deductive method of general practice history-taking does use a scientific method and therefore acknowledges the complexities of different realities from different viewpoints. This is summarized in the 'physical, psychological, and social' model for diagnosis, each facet being arrived at using a hypothetico-deductive, i.e. scientific, method.

Furthermore, the idea that there can be more than one view of 'reality' has been extensively elaborated from within the scientific tradition. Relativism, uncertainty,

the acceptance of doubt, understanding that the observer influences events, and that the mind creates rather than simply measures our view of the external world are all scientific ideas. Evolution, quantum mechanics, genetics, linguistics, and the science of the mind and brain all use ideas that are recognizable in postmodernism while also being clearly scientific in origin. If any ideas should be contrasted to scientific postmodernism they are the concepts of authority, hierarchy, and moral absolutes deriving from the monotheistic culture that has dominated European medicine for hundreds of years.

Mathers and Rowland have made an important attempt to put general practice firmly into an up-to-date intellectual context. It is a shame that they went awry.

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## Exercise prescription in primary care

Sir,

I read with interest the editorial on exercise prescription in primary care (*May Journal*) and would like to comment on the perceived 'current state of knowledge'.

First, the flaws in Hillsdon's review<sup>1</sup> of the literature have already been pointed out in the *British Journal of Sports Medicine*.<sup>2</sup> The paper reviews randomized controlled trials of physical activity promotion in apparently healthy, free-living adults from the United States and Switzerland. It concludes that their findings do not support the promotion of physical activity to patients with disease states in the United Kingdom by general practitioner (GP) referral exercise prescription schemes. Only telephone follow-up was made in many cases, and the majority of home-based programmes described had no post-intervention follow-up. It is therefore flawed to conclude that these were more likely to result in a long-term change in physical activity behaviour.

Secondly, the annual review of the 10 GP referral schemes operating in East Sussex under a common protocol show that approximately 2000 patients a year pass through the schemes, with an average adherence rate of 60% over the 10-week period. Adherence is defined as the sub-

ject attending at least 75% of sessions and receiving an exit evaluation of interview and physiological examination. The range for adherence varies from 40% to 95% from sports centre to sports centre, and it is not the referring GP who is the most important predictor of success: this is largely a variable of the size of the scheme and the staff time available. A scheme that takes just 2–3 new patients a week and involves the practice nurse has the highest adherence rate but is most costly on a per patient basis. Schemes taking 10 new patients a week have the lowest adherence rates but cope with a greater volume of subjects. In terms of health care and costing we need to consider what would be the optimum number of referrals each week and what staff time is available.

We, in East Sussex, have achieved our much-improved adherence levels through the following methods:

- The setting up of a co-ordinated strategy for referral schemes across the county with a common protocol<sup>3</sup>
- The development of the first university-accredited training course<sup>4</sup> for prescription for exercise instructors and practice nurses
- The development of a training module and handbook<sup>5</sup> for participating GPs, and
- The development with Wealdon District Council of a software package<sup>6</sup> specific to the needs of the scheme.

Our practice has changed considerably over the five years that we have been operating, and, owing to an absence of funding for research, our efforts have been devoted to these developments rather than to the publication of results. There is a danger that academics set up schemes to evaluate whether the concept of GP referral to leisure is effective without understanding what is best practice. If you do not educate the GPs or train the instructors, the scheme will be poor and you will only appreciate this through experience in this field. Research is not always good research.

Finally, neither unpublished manuscripts nor personal communications, as described in the editorial, are sound bases for policy. The authors also seem to be confusing two issues: one is the general promotion of increased levels of physical activity where walking programmes are beneficial, and the other is getting sedentary patients with certain disease states to perform sufficient activity to influence the condition based upon the risks and benefits of exercise for that individual.<sup>7</sup> Both

are required but need different methods.

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### Oral anticoagulation in primary care

Sir,

I was pleased to see two further articles regarding oral anticoagulation in primary care in the May edition of the *BJGP*.<sup>1,2</sup>

These are both useful articles highlighting the need for improved anticoagulation monitoring in general practice, which could, in turn, lead to improved clinical outcomes for patients, particularly those with non-rheumatic atrial fibrillation. Both articles, however, over-emphasize previously published work regarding anticoagulation monitoring by GPs. Lip *et al* state that 'anticoagulant monitoring by GPs is much better than that in hospital clinics', while Rogers *et al* state that 'anticoagulant control in general practice can be superior to that obtained in a dedicated hospital outpatient clinic.' Both these statements are derived from the same paper,<sup>3</sup> which in fact showed poor control for both hospital and general practice clinics, with only around 50% of

patients achieving therapeutic international normalized ratios (INRs).

The only substantive paper to show significant improvement in INR control by GPs was published in the *British Journal of General Practice* and involved the use of computerized decision support.<sup>4</sup> Given that this model has been shown to work also in combination with near-patient testing, I would have to agree with Rogers *et al*'s conclusion that any shift of warfarin management to primary care would need a careful planning of services and appropriate resources to meet potential demand.

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### Peer-supported learning

Sir,

In their editorial, Paul Sackin and colleagues (February *Journal* p67) describe their system of co-tutoring in East Anglia and conclude: 'It is clear that the support offered by this process builds a foundation that has helped some participants to bring about major changes in their lives and practices.' We accept that support is an important component of professional development that may be lacking in many GPs' environments,<sup>1</sup> but to attribute these reported changes to their scheme seems premature on the presented evidence.

Behaviour change by GPs is known to be influenced by many differing factors,<sup>2,3</sup> and a recent study found six factors accounting for 76% of the reasons given for change, with contact with fellow pro-

professionals accounting for only 13.6%.<sup>4</sup> There is a growing acceptance among GPs that small group techniques are a more appropriate educational method, as 86% of responders to one recent survey favoured small groups<sup>5</sup> compared with 25% in 1988.<sup>1</sup> However, adult learning principles suggest that other factors, such as problem-based casework, are just as important as participation, and 'discussions may become a sterile exchange of prejudices' if not managed by the tutor, and so frustrate the learner.<sup>6</sup>

Sackin *et al* criticize young practitioner groups for 'erring on the side of cosiness,' but we are not given details of how this can be avoided in their model. Helping the learner to define educational needs (real needs rather than 'wants'<sup>7</sup>) may be an important function of the mentor, as are support and active listening, but there are other relevant processes that have not been mentioned. Support alone is not enough, and challenging assumptions and perspectives are important in any mentoring relationship.<sup>8</sup> Another process of paramount importance is the process of conscious reflection to enhance learning,<sup>9</sup> and the role of the mentor in this process is crucial.<sup>10</sup>

Sackin *et al* are to be congratulated on bringing peer-assisted learning to the attention of GPs, but at present there still seem to be more questions than answers, and we will await further details on their project with interest.

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### Keeping the meningococcus out of the media

Sir,

I am grateful for the editorial by Pollard and Booy (*April Journal*),<sup>1</sup> which raises several important points. First, there's still confusion both among the public and among some practitioners as to whether the definition of the term meningococcal 'meningitis' includes both meningococcal meningitis and meningococcal septicaemia, which are, in fact, very different diseases.<sup>2</sup> Although the two conditions can coexist, they often occur separately, even though they are both caused by the same bacterium, *Neisseria meningitidis*.<sup>3</sup> This difference should be stressed because the septic form is considerably more severe than the meningitis form which limits itself to the meninges. The case-fatality of meningococcal septicaemia is tenfold that of meningococcal meningitis, which is generally less than 5%.<sup>4</sup> This is important because a case or outbreak of meningococcal septicaemia may be referred to by the media as 'meningitis', bringing to the affected population an anxiety that may itself become a health problem.<sup>5</sup> Furthermore, the focus of worried patients as a result of the media is to look for the classic signs and symptoms of meningitis. However, education of the public would be better aimed at the natural history of meningococcal septicaemia, a more non-specific illness, where concern should concentrate on the often classic vasculitic rash and rapid clinical deterioration.<sup>3</sup>

Second, research into meningococcal 'meningitis', more recently referred to as meningococcal disease,<sup>4</sup> should also concentrate on the natural history of meningococcal septicaemia as a consequence of its

high mortality. The purpose of this research should be two-fold: to manufacture a vaccine against type B meningococcus, which is thought to be the cause of nearly 70% of cases of meningococcal disease, and to determine how to make the diagnosis earlier.

It is with the latter aspect that I am concerned as a GP, having conducted pilot survey of GPs asking, 'Can you recall a case of meningococcal septicaemia that, in retrospect, if one or more distinguishing features were to appear in another patient, they might lead you to suspect the condition earlier?' I am presently performing a qualitative analysis of this information, and if any GP has a personal experience in this area I would be grateful if they would write to me anonymously with details.

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### RCGP Council elections

Sir,

I have just received the election details for Council members. Despite now having reached the venerable age of 48, I was struck by how old the candidates are. The average age is 54, only three candidates were born in the 1950s, and only one from the 1960s.

In no way do I wish to imply that age cannot bring wisdom, but I do believe that we should be concerned about the situation. What was the average age of candidates in the past? If they are getting significantly older, then there is clearly a problem.

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### 97% of GP trainers can't be wrong

Sir,

Lough and Murray entitled their latest opus 'Training for audit: lessons still to be learned' (May *Journal*).<sup>1</sup> I agree, but just with the title, for it is the authors who may have most to learn.

First, it appears they may have been using the 'career enhancing software' developed by Craddock<sup>2</sup> and Morrison,<sup>3</sup> because five of the references cited are to their own papers, including one 'in press'.

Secondly, the paper raises a far more serious issue. Audit has been introduced into summative assessment for GP vocational training almost entirely through the work of these two authors and despite the reservations of others. They now describe how 114 experienced GP trainers were asked to assess five audits for minimal competence, and note that only 3 (3%) 'correctly identified the five criteria that were below minimal competence', and then only by 'exhibiting 'hawkish' behaviour in their marking'. So, 97% of experienced GP trainers disagreed with them, yet the conclusion drawn is that these 'experienced GP trainers are struggling to recognize even basic audit methodology...(and)...are also unaware of this deficiency'.

There is, of course, an alternative interpretation. The issue is that of the minimal competence necessary to practise as a GP. Can 97% of experienced trainers really be so wrong? Or have the authors simply demonstrated the fallacy of their assessment tool, and shown that the audit component of summative assessment is fatally flawed? And have the Joint Committee of Postgraduate Training, and indeed the profession itself, been unwitting recipients of the 'undetected sophistry' so eloquently described by Silverman?<sup>4</sup>

While it is embarrassing to witness generals castigating their troops in public, it remains remarkably pleasing to observe them shooting themselves so accurately in the foot.

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### Like mother, like daughter

Sir,

Seamark and Gray concluded that their study (March *Journal*) confirmed that pregnant teenagers today are more likely than their non-pregnant counterparts to have a mother who had a teenage pregnancy, and that their findings could help to identify those at risk of teenage pregnancy.<sup>1</sup> This paper deserves a comment because of the importance of the subject of teenage pregnancy. While their study highlights the possible influence of a girl's mother having experienced a teenage pregnancy on the chances of the girl experiencing the same, it cannot be an isolated variable. Other, confounding variables may influence this risk.

First, the social and sexual milieu operating in the 1990s is different from that of their mothers' teenage years. The pervading influence of peer pressure and certain aspects of modern life, including films, radio, and television advertisements that tell teenagers that sex is exciting and titillating, cannot help matters in the fight to reduce teenage pregnancy. In the 1990s, the daughters of teenage mothers are more likely to continue their pregnancies because of today's more liberal attitudes to such events.

Secondly, there may also be paternal influences on the likelihood of teenage daughters becoming teenage mothers, such as the possibility of the father having been a teenage father himself.<sup>2</sup>

Thirdly, a link between sexual abuse and risk of teenage pregnancy is becoming apparent.<sup>3</sup> It is possible that the mothers of these pregnant teenagers became pregnant as a result of sexual abuse and that the same factor operated in their daughters' pregnancies. This study missed the opportunity to assess the influence of this factor because, being a study performed in a single general practice, the records of both mothers and daughters were readily available and, if there were histories of sexual abuse, these would have been obvious.

Finally, while we agree that the result of this study may help in identifying girls at risk of teenage pregnancy, we feel that it should not be used in isolation.

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### *Helicobacter pylori* eradication

Sir,

Hippisley-Cox and Pringle (June *Journal*) report on pre- and post-intervention acid suppression treatment costs for patients undergoing *Helicobacter pylori* eradication, and also for a group of control patients. What is of interest is that the controls demonstrated an increase in their six-months' median acid suppression treatment costs from £91 to £109, despite the number of patients in this group falling from 15 to 14. Is this increase due solely to the cost of the omeprazole in the eradication regime received by three of these patients? The authors fail to comment on this and on the fact that the mean symptom score for all patients, and in particular for control patients, seems to reflect poor overall control of gastrointestinal symptoms, even though patients were supposedly receiving maintenance acid suppression therapy.

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Correction: In the June issue, the title of Dr Adrian Morris' letter (p406) was printed as follows: 'Non-compliance to long-term asthma treatment - our greatest achievement.' The correct title should read, 'Non-compliance to long-term asthma treatment - our greatest challenge.' We apologise for any confusion this error may have caused.