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.

Return consultations

Sir, De Elkington (April Journal)[1] raises the interesting speculation that return consultations may reduce stress for GPs. This is an understandable concept in that uncertainty, a potential cause of stress, may thereby be reduced. I note however, that in the same *Journal* it is suggested that 'extras' may also be a source of stress.[2] It would appear, therefore, that the partners of a GP who sees a high number of return patients, thereby not being available for new consultations, may indeed be those doctors who are under the greatest stress!

I join with Dr Elkington in asking if more work is required to satisfactorily solve this dilemma. I write as an interested GP who was unable to alter the return consultation rate of my former partners. I left the practice in order to develop my career without these particular stresses.

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References

1. Elkington H. Relationship between new and return consultations and workload in general practice. *Br J Gen Pract* 1999; **49:** 315.
2. Kendrick T, Kerry S. How many surgery appointments should be offered to avoid undesirable numbers of 'extras'? *Br J Gen Pract* 1999; **49:** 273-276.

Primary care group commissioning of services

Sir,
Barclay *et al* (March *Journal*)[1] addressed an important issue in their paper on commissioning priorities. GPs and district nurses provide most of the palliative care in the UK and, through primary care groups, will soon be commissioning services. Their views should be influential.

It is unfortunate, therefore, that although the authors showed significant differences between the choices of district nurses and GPs, the measuring tool did not discriminate clearly between preferences for different services. The authors used a four-point Likert scale, which compelled responders to express an opinion one way or another, but produces a set of responses skewed to the positive end of the range. All the mean district nurse scores and eight out of 11 of the mean scores were above three. This 'ceiling effect', where replies cluster at the end of a scale, makes it impossible to determine which of the services really were priorities.

General practitioners see palliative care as a central part of their role,[2] and it is possible that participants were reluctant to suggest that any palliative care services were 'fairly unimportant'. A neutral midpoint on the scale may have been useful in this case. If likely GP views had been anticipated, the scale could have been altered to increase its ability to discriminate between the different options. For example, the middle of the scale would have been expanded, or more options provided above the midpoint.[3] The authors suggest that their results indicate that all the services should be developed and none are dispensable. This may reflect accurately the views in primary care; it may equally have been produced by their choice of scale.

The finite nature of health service resources is widely accepted. The failure of this paper to distinguish between a number of different priorities limits the value of its results. If primary care groups accept the authors' suggestions to use this method to canvas professional views, they should choose their measuring tool with care.

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References

1. Barclay S, Todd C, McCabe J, Hunt T. Primary care group commissioning of services: the differing priorities of general practitioner and district nurses for palliative care services. *Br J Gen Pract* 1999; **49:** 181-186.
2. Fordham A, Dowrick C, May C. Palliative medicine: is it specialist territory? *J R Soc Med* 1998; **91:** 568-572.
3. Streiner DL, Norman GR. *Health measurement scales: a practical guide to their development and use.* [Second edition.] Oxford: Oxford Medical Publications, 1995.

Survey of GP registrars' opinions of summative assessment and perceived effect on the training year

Sir,
We wish to report the results of a pilot study to assess the burden of summative assessment for GP registrars and its effect on the training year.

Summative assessment became compulsory for GP registrars from 31 January 1998. The process was not intended to interfere with or dominate registrar year,[1] but no study has yet attempted to quantify its impact on the educational potential during this period. Traditional medical education trains doctors to pass exams to the best of their ability. The concept of minimum competence is clearly alien to many, and its prescriptive programme seems incongruous with promoting a culture for developing professional knowledge that ought to be needs led, reflective, and flexible.[2]

Anonymous questionnaires were sent to all 96 registrars in their training year in the Southwest in June 1997, asking them to quantify times taken to complete the various tasks and ascertaining attitudes towards summative assessment. A response rate of 66% was achieved and no reminders were sent.

Forty per cent admitted to spending no time preparing for the multiple-choice questions; 33% took eight weeks prepar-

ing the audit. The Joint Committee on Postgraduate Training for General Practice recommends that a two-hour videotape of consecutive consultations, with little, if any, editing would normally suffice.[3] Only 5% of registrars in our survey completed the video in this recommended time. The trainer's report was felt to be rigid, uninformative, and insulting. Seventy-five per cent of registrars agreed with the requirement for summative assessment, but 65% felt the process should be modified. Only 11% felt it should continue in its present form.

Forty-five per cent expressed a view that the future of summative assessment should involved the MRCGP examination, perhaps seeing one standard to satisfy minimum competence and one as the gold standard of vocational training. A survey in Devon and Cornwall has reported a 40% deferral rate for the College examination from the registrar year, with summative assessment cited as contributory, but not exclusively responsible, for this decision (Steele R. Personal communication, 1998).

This small survey shows that registrars believe a system of assessment is necessary, but, in its present form, summative assessment is more intrusive to the registrar year than intended and too labour intensive for minimum competence. Eighteen months in general practice could alleviate some of these perceived difficulties and allow more educational needs to be addressed. It is hoped that summative assessment will evolve with the MRCGP to continue upholding standards in the profession.

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References

1. Campbell LM, Murray TS. Summative assessment of vocational trainees: results of a three year study. *Br J Gen Pract* 1996; **46:** 411-414.
2. Pearson P, Jones K. Developing professional knowledge: making primary care education and research more relevant. *BMJ* 1997; **314:** 817-820.
3. Joint Committee on Postgraduate Training for General Practice. *A guide to certification.* London JCPTGP, 1997.

Methods for assessing GP performance

Sir,
Plus ça change?

I found the article, 'Commentary' by Simon Fradd (April *Journal*, Back Pages),[1] describing the methods to be adopted by the General Medical Council for assessing a GP's performance, of great interest.

In one paragraph he writes, 'If found seriously deficient at this point, a formal heating (sic) is arranged before a panel of doctors and lay people…' Can we assumed from this that auto-da-fé is to be reintroduced?

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References

1. Fradd S. Commentary. [Back Pages.] *Br J Gen Pract* 1999; **49:** 331.

The physician healer

Sir,
In their paper (April Journal),[1] Dixon, Sweeney, and Pereira Gray discuss how to bridge the divide between a hard, scientific view of medicine and the more gentle, age-old view of a healing art. They distinguish practice based upon guidelines derived from the interpretation and implementation of placebo-controlled trials from an approach based upon the doctor's own personal skills and ability to harness the non-specific healing effect of the placebo response.

The discussion, however, is based on the false premise that such a gap exists. At the outset the authors comment that, 'The therapeutic role of general practitioners is one that, over the years has slowly diminished', and lay the blame at the foot of evidence-based medicine. Yet, in strict pharmacological terms, the drugs routinely prescribed by GPs are more therapeutically potent than ever before. However, as rightly pointed out, patients wish for a service that goes far beyond simply prescribing. Availability and continuity of care are seen as very important. Patients want their concerns understood and valued by a doctor who has time to offer a caring and sympathetic consultation. To develop a therapeutic relationship, which itself has healing properties (Balint's 'drug doctor'[2]), requires both a skillful practitioner and the trust of the patient. The essential trust is based on the understanding that a doctor has a knowledge of pathophysiology and pharmacology that enables them to diagnose, offer a prognosis, and suggest appropriate therapy. Thus, a practitioner is assumed to be reasonably up-to-date with ongoing research or, what has come to be described as, evidence-based medicine.

Using the results of placebo-controlled data to guide the prescribing of medicines does not diminish the need for other, more personal skills, nor does it belittle the powerful placebo response to a trusted doctor. Guidelines based on the best of such evidence should not be feared as diminishing the doctor's role; the key element is 'guide'. They may be used to predict which intervention is likely to produce a particular outcome, but the aim of treatment and choice of appropriate therapy must still be negotiated in partnership with the patient. It would be a mistake to regard these very different elements of medicine as in competition or to divide doctors in such a way. Instead, let the RCGP's own motto, '*Cum Scientia Caritas*' (scientific skill with loving-kindness'[3]), guide our care of patients and be a stimulus to future research.

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References

1. Dixon DM, Sweeney KG, Pereira Gray DJ. The physician healer: ancient magic or modern science? *Br J Gen Pract* 1999; **49:** 309-312.
2. Balint M. *The doctor, his patient and the illness.* London: Pitman Medical, 1952; 231.
3. McCulloch GL. The James Dundas Simpson Address: Cum Scientia Caritas. *J R Coll Gen Pract* 1969; 18: 315-320.

Sir,
The art of the physician healer in general practice is revived in the April *Journal*.[1] Patients' priorities are 'to have a doctor who listens and explains clearly, who allows sufficient time for consultation, and with whom they are able to get an appointment'.[2] How is this to be achieved if GPs are now to spend more time managing health provision?

The April *Journal* also reports a study of 'extra' appointments.[3] Patients asking for an immediate appointment want sym-

pathetic advice about their concerns. Nurses are good at listening, explaining, and understanding.[4] A 1995 study[5] showed that over 80% of same-day requests were dealt with by a nurse with no doctor contact. An editorial in 1996[6] was followed by correspondence (November 1996 *Journal*), but there has been little since to suggest that a wider role for nurses has spread.

This wider role requires true sharing of care between nurses and doctors so that a partnership including patients evolves; it requires some education for both nurses and doctors. This can be achieved in practice with suitable advice, especially about the sharing of skills.[7] Current nurse practitioner education may accentuate professional independence.

Like doctors, young nurses are in short supply. However, the wider role should be ideal for the nurse returning to the profession when her children are older. She would bring the experience of life with a young family that is needed. There is a good supply of such nurses. Perhaps their help should now be sought more actively?

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References

1. Dixon DM, Sweeney KG, Pereira Gray DJ. The physician healer: ancient magic or modern science? *Br J Gen Pract* 1999; **49:** 309-312.
2. Anon. What makes a good GP? *Which* 1995; **June:** 18.
3. Kendrick T, Kerry S. How many surgery appointments should be offered to avoid undesirable numbers of 'extras'? *Br J Gen Pract* 1999; **49:** 273-276.
4. Salisbury CJ, Tettersell MJ. Comparison of the work of a nurse practitioner with that of a general practitioner. *J R Coll Gen Pract* 1988; **38:** 314-316.
5. Marsh GN, Dawes MI. Establishing a minor illness nurse in a busy general practice. *BMJ* 1995; **310:** 778-780.
6. Davis PJM. Accessibility and availability: how can we cope? [Editorial.] *Br J Gen Pract* 1996; **46:** 449.
7. Rashid A, Watts A, Leneham C. Skill-mix in primary care: sharing workload and understanding professional roles. [Editorial.] *Br J Gen Pract* 1996; **46:** 639-640.

Sir,

It was very gratifying to read the paper by Drs Dixon, Sweeney, and Professor Pereira Gray on the 'physician healer' in the April *Journal*.[1] Too long have doctors been taught to become detective inspectors of disease in their patients, which doctrine has naturally been enhanced by the use of new scientific advances.

Some 50 years ago, an attempt was made to study the effect of the mind on the body under the term 'psychosomatic medicine', but the real step forward towards the physician becoming a healer took place when that outstanding psycho-analyst, Michael Balint, arrived here from Budapest and started his famous seminars for GPs, with a study of the doctor-patient relationship. Balint achieved a worldwide reputation from his Socratic method of teaching, and the legacy he left was fully described by Dr McWhinney in his essay in the May *Journal*.[2]

No article on the physician healer would be complete without a reference to the Greek philosopher Plato, who had studies under Socrates and hand mentioned the subject of healing in a passage in his book on the LAWS in the 4the century BC. Here is the passage as translated by Jowett in his *Dialogues of Plato*:

> Did you ever observe that there are two classes of patient in states, slaves and freemen; and the slave doctors run about and cure the slaves, or wait for them in the dispensaries — practitioners of this sort never talk to their patients individually, or let them talk about their own individual complaints? The slave doctor prescribes what mere experience suggests, as if he had exact knowledge; and when he has given his orders, like a despot, he rushes off with equal assurance to some other servant who is ill; and so relieves the other doctor, who is a freeman, attends and practises upon freemen; and he carries his enquiries far back, and goes into the nature of the disorder; he talks with the patient and with his friends, and is at once getting information from the sick man, also instructing him as far as he is able, and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure.[3]

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References

1. Dixon DM, Sweeney KG, Pereira Gray DJ. The physician healer: ancient magic or modern science? *Br J Gen Pract* 1999; **49:** 309-312.
2. McWhinney IR. Fifty years on: the legacy of Michael Balint. [Back Pages.] *Br J Gen Pract* 1999; **49:** 418-419.
3. Jowett B. *Dialogues of Plato.* [Volume 5.] Oxford: Clarendon Press, 1982.

Preclinical medical students' knowledge of *Chlamydia* infection

Dr Catti Moss recommends that medical school education should include education in sexual history taking and sexually transmitted diseases (STDs) (May *Journal*; Back pages).[1] We conducted a confidential questionnaire survey of first and second year medical students at St George's Hospital Medical School to investigate their knowledge of *Chlamydia* infection.

In March 1999, all 350 students attending end-of-term examinations were asked to complete a brief questionnaire about *Chlamydia*. The response rate was 79% (275/350). Mean age was 20 years (range = 18–35 years). Forty-seven per cent of responders were male; 56% of responders described their ethnicity as white, 29% Indian subcontinent, 10% Chinese/SE Asian, 1% Black African, 1% Afro-Caribbean, and 3% other ethnic groups.

Only 66% (181/275) of medical students had heard of *Chlamydia*. In addition there was a difference in knowledge of *Chlamydia* between men and women: 45% (59/130) of men knew that *Chlamydia* was an STD compared with 61% (89/145) of women (relative response [RR] = 0.7; 95% CI = 0.6 to 0.9); 13% (17/126) of men knew *Chlamydia* could cause pelvic inflammatory disease and infertility compared with 36% (50/140) of women (RR = 0.4; 95% CI = 0.2 to 0.6); 35% (46/130) of men knew that the risk of catching Chlamydia could be decreased by use of barrier methods or few partners compared with 49% (71/145) of women (RR = 0.7 (95% CI = 0.5 to 0.96).

These results suggest a lack of knowledge of *Chlamydia* infection among British preclinical medical students, and especially among male students. Since the students had not yet studied sexual health at medical school, this is likely to reflect education at secondary school level. Medical students might be expected to have a higher level of knowledge than other university students and British youth in general. We agree with Dr Moss that GPs should stop being embarrassed about sex and take every opportunity to promote sexual health among young people, including teaching medical students.

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References

1. Moss C. No Sex, Please – We're British General Practitioners! [Back Pages.] *Br J Gen Pract* 1999; **49:** 409.

Pat on the back

Sir,

I Just thought I'd hit the keyboard to say something nice about he Journal for a change.

Now, when you've climbed back on your seat after the shock made you fall off, I'll detail why I'm feeling so generous.

I admit to not waiting with bated breath for the Journal to hit my mat so I can tear open the cover as soon as it arrives. But I do read it every month — though I do so backwards. I start with the Back Pages, then read the letters and the editorials, before finally scanning the original papers.

Not April's issue though. Straight in to Mike Pringle's1 editorial on revalidation — meaty stuff this. And the, for some distracted reason, I began to flick through the papers, only to find the Back Pages would have to wait as I read 'all' of them!

Forgive my surprise, but I can honestly say that in the seven years I've been reading it, this is the first time I've done so from choice. But who can blame me? Peter Burrows and Liz Bingham's[2] simulated surgery paper was fascinating. Taylor's attempt at explaining the reasons behind retention of young GPs[3] even had me writing to you. And then, just as I was looking forward to the letters, came Dixon *et al*'s inspiring piece on the physician healer.[4] I think most GPs — if they are a) any good and b) honest — recognize a little of the physician healer in themselves; I certainly do. Indeed, I would go so far as to call myself a 'fortunate man'; this paper describes, for me, what is the very essence of general practice. Come to that, so did April's Journal.

Good effort, keep it up.

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References

1. Pringle M. Revalidation. *Br J Gen Pract* 1999; **49:** 259.
2. Burrows PJ, Bingham L. *Br J Gen Pract* 1999; **49:** 269-272.
3. Taylor Jnr DH, Quayle J, Roberts C. Retention of young general practitioners entering the NHS from 1991-1992. *Br J Gen Pract* 1999; **49:** 277-280.
4. Dixon DM, Sweeney KG, Pereira Gray DJ. The physician healer: ancient magic or modern science? *Br J Gen Pract* 1999; **49:** 309-312.

Patients removals: can we achieve a balance?

Sir,

Being 'struck off' a GP's list is an unsatisfactory conclusion to the doctor-patient relationship and has generated considerable agitation among patients and concern in the media.

It is estimated that about 30 000 patients are removed from GPs' lists each year in the United Kingdom, though rates vary with studies in Sheffield[1] and Fife[2] having reported higher rates than in Northern Ireland.[3] In Northern Ireland this equates to one new removal decision per practice (average list of 5000) per year, which is significantly lower than, for example, the current divorce rate of 13.5 per 1000 marriages per annum.4 Recent evidence has demonstrated that, while removals were relatively rare events for both patients and practices, they have been increasing in recent years, especially in the elderly.

In one study, GPs cited verbal or physical abuse, behaviour that was distressing to other patients or staff, drug abuse and breakdown of the doctor–patient relationship as antecedents for removing patients.[2]

Various professional organizations, including the Royal College of General Practitioners,[5] have all issued guidance to GPs suggesting that, where possible, patients should be given a reason as to why they are being removed in order that patients may perceive the problem(s) leading to a breakdown in their relationship.

Some patients are stigmatized by removal and, in his Annual Report 1997/98 and subsequent action, the Health Service Ombudsman has established the right of patients to formally complain about their removal in instances where no reason had been given.

General practitioners are cautious about issuing written warnings to patients, and support the current process, which they feel protects them from protracted argument. They also feel vulnerable to revenge attacks and see this as a vital safeguard of last resort.[2] Alternatively, excessive use by GPs of their 'right to remove' could lead to vulnerable patients being disadvantaged in their access to primary care services. GPs are also professionally accountable to health authorities and have a collective responsibility for difficult patients. A report from the Department of General Practice[2] in Edinburgh suggests a compromise. GPs should still have the right to remove patients but also would be required to provide the health authorities with a reason using a list of agreed categories. The process of removal would become more open by introducing professional scrutiny, and health authorities could monitor trends and identify discriminatory practice.

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References

1. Munro J, Stinner J. Unwelcome customers? The epidemiology of removal from general practitioners lists in Sheffield. *Br J Gen Pract* 1998; **48:** 1837-1839.
2. Macleod L, Hopton J. A study of the process of removing patients from general practitioners lists. [Report of General Practice.] Edinburgh: University of Edinburgh, 1998.
3. O'Reilly D, Steele K, Merriman B, et al. Patients removals from general practitioners lists in Northern Ireland 1987-96. *Br J Gen Pract* 1998; **48:** 1663-1673.
4. Office for National Statistics. *Population and Health. Key Data 1948-97.* London: HMSO, 1998.
5. Royal College of General Practitioners. *Removal of Patients from GPs lists.* London: RCGP 1997.

Tackling antibiotic resistance

Sir,

Directives aimed at curbing the use of antimicrobials to prevent the emergence of multi-resistant pathogens[1,2] are to be welcomed if, to quote Richard Smith,[2] we are serious about avoiding 'health care's version of global warning'. Changing patterns of antibiotic prescribing, however, must be allied to more precise diagnosis. For instance, delays in diagnosing group A streptococcal infections, which still account for 30% of paediatric and 10 to 15% of adult pharyngitis, are likely to lead to a resurgence of serious sequelae such as acute rheumatic fever and post-streptococcal glomerulonephritis. Recently, three children suffering from acute rheumatic fever have been treated in Leeds hospitals compared with a single documented case

in the previous five years. Whether or not this is a chance occurrence remains to be clarified. What is known is that none of the children received antibiotics or had throat swabs taken on first presentation.

We performed a survey of GPs chosen randomly from the Leeds/Bradford area, regarding their antibiotic prescribing practices for treating sore throats and uncomplicated chest infections. Of the 50 GPs contacted, 82% reported that they had been influenced by efforts to restrict and rationalize antibiotic prescribing. Although they were writing fewer prescriptions for antibiotics, only 20% claimed that they were making more use of laboratory tests to reach a microbiological diagnosis at the first consultation. However, an audit of throat swabs sent by GPs over the past 36 months to the microbiology department at Leeds hospital has not shown any increase in sample numbers. The delay in obtaining results of cultures was cited as the main reason for not taking specimens for microbiological evaluation. Instead, empirical treatment with an antimicrobial was the preferred practice if symptoms were not improving after 72 hours, as if the policy elsewhere.[3] How can streptococcal infection be diagnosed promptly and reliably without throat culture?

The detection of group A streptococcal antigen from throat swabs may provide a simple solution.[4,5] Testing takes only a few minutes and can be performed in the surgery. Whereas earlier detection kits demonstrated low sensitivity, modern immunoassy diagnostic tests provide high sensitivity and specificity, each exceeding 95%, which is comparable and sometimes even more sensitive than traditional blood agar culture.[5] This rapid means of diagnosis has gained popularity in some countries, but few GPs (8%) to whom we spoke knew about them. Nearly all the doctors taking part in this survey expressed an interest and 80% were keen on being given the opportunity to test the diagnostic kits.

If widely used, streptococcal antigen detection tests might represent a potential cost saving — negative results would not routinely require confirmation by laboratory culture,4,5 streptococcal infections could be treated promptly and so minimize cross infection, and unnecessary antibiotic therapy would be avoided.

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References

1. Abbasi K. Report calls for action on antibiotic resistance. *BMJ* 1998; **316:** 1261.
2. Smith R. Action on antimicrobial resistance: Not easy, but Europe can do it. *BMJ* 1998; **317:** 764.
3. Cates C. An evidence based approach to reducing antibiotic use in children with acute otitis media: controlled before and after study. *BMJ* 1999; **318:** 715-716.
4. Gerber MA, Tanz RR, Kabat W, *et al.* Optical immunoassay test for group A β-hemolytic streptococcal pharyngitis: an office-based, multicenter investigation. *JAMA* 1997; **277:** 899-903.
5. Supon PA, Tunnell S, Greene M, Ostroff RM. Rapid detection of group A streptococcal antigen with a new optical immunoassay. *Pediatr Infect Dis J* 1998; **17:** 349-351.

Repeat prescribing management — a cause for concern?

Sir,

The paper on repeat prescribing management by McGavock *et al* (May *Journal*)[1] is definitely a game of two halves. The plainly fastidious design of the study is spoiled by a discussion section that is both difficult to understand (such as 'at worst this study reports the minimal incidence of inadequate repeat prescribing management and the actual incidence for those survey items not seen by respondents as judgmental') and full of value statements that are neither referenced nor related to the main text. Thus, 'the main finding of this study is that repeat prescribing is *poorly* managed'; '*mandatory* checks are often omitted'; 'opportunities for quality assurance are often missed'; 'mean review intervals appear excessive'; 'our results should generate *great concern* among GPs and their administrators'. On the other hand the authors were encouraged to find that 'the superior practice management skills required for fundholding are translated into somewhat *better* repeat prescribing management', and they conclude by claiming both to identify and quantify '*serious deficiencies*' in many aspects of repeat prescribing management (our italics).

Frankly, these alarmist statements and value judgements are not borne out by the results of the study, nor is there any evidence to support the contention that patients are being reviewed insufficiently frequently, other than by an unreferenced report from the National Audit Office — this is the first time we have seen this institution being used to support a purportedly serious scientific paper.

We would be alarmed if this paper were taken seriously by the GPs and administrators to whom the authors allude.

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References

1. McGavock H, Wilson-Davies K, Connolly JP. Repeat prescribing management – a cause for concern? *Br J Gen Pract* 1999; **49:** 343-347.

Correction

In the June issue of the Journal we published a letter entitled 'Chlamydia infection in women'. The author (Pippa Oakeshott) would like to acknowledge that the study was funded by the South Thames Project Grant Scheme, and to thank the patients, nurses, and doctors based at the following practices: Acorn Practice, Balham Health Centre, Balham Park Surgery, Battersea Rise Practice, Bridge Lane Health Centre, Brocklebank Health Centre, Earlsfield Practice, Falcon Road Medical Centre, Garratt Lane Surgery, Greyswood Practice, Lavender Hill Group Practice, Mitcham Medical Centre, Queenstown Road Practice, Southfields Group Practice, Tod Practice, Tooting Bec Surgery, Triangle Surgery, Trinity Road and Cavendish Road Partnership, Waterfall House, Winstanley Group Practice, 4 Ashvale Road, 7 Farrant House, Winstanley Road, 13-15 Barmouth Road, 47 Boundaries Road, 51 Princes Road, 119 Northcote Road, and 263 Lavender Hill.