

Steroid injections <i>John S Dowden</i>	836	Primary care research <i>D P Kernick</i>	837	Simulated surgery <i>P Burrows and L Bingham</i>	840
Repeat prescribing management <i>H McGavock, K Wilson-Davis and P Connolly</i>	836	Living wills <i>M Wilks</i>	838		
Nursing home residents: demands on GPs <i>P M Craig-McFeely, J R Sedgwick, S Holden and D J Berry</i>	836	Encouraging GPs to write scientific papers <i>J Ramsay</i>	838		
Child health surveillance <i>T Boggis</i>	837	Reducing antimicrobial resistance in Spain <i>C Llor and M Angel Mayer</i>	838		
Motivational consulting <i>A McKnight, M Cupples and G P R Archbold</i>	837	Data management in primary care <i>A Rannard, J Bogg and P Bundred</i>	839		
		Clinical skills assessment <i>Moya H Kelly and T S Murray</i>	839		

Steroid injections

Sir,

I am not encouraged to give more intra-articular and peri-articular injections by the results of Kumar and Newman's study (June *Journal*).¹ While their results may be reassuring, they cannot be assumed to represent what might happen in general practice. Both authors are specialists and some of the injections not given by them personally were probably given by doctors with some specialist training.

The large number of injections given in the study means that 'all grades of staff' had plenty of opportunity to practise their technique. Specialist supervision would have been readily available. This is not the situation in general practice, where joint injection may only be infrequently indicated.

In these litigious days, can we still have a go at a procedure we may never have done before? If you inject a knee and cause septic arthritis that results in legal action, it will not just be the patient who does not have a leg to stand on.

JOHN S DOWDEN

Calwell Medical Centre
Calwell Act 2905
Australia

Reference

1. Kumar N, Newman RJ. Complications of intra- and peri-articular steroid injections. *Br J Gen Pract* 1999; **49**: 465-466.

Repeat prescribing management

Sir,

In response to the letter from Drs Cubitt and de Quincey (July *Journal*),¹ it is not unusual for clinicians to experience major difficulties when confronted with research that has used techniques specific to the social sciences and more specialized statistics. At the outset of our discussion section,² we explain that the semi-structured

questionnaire is a recognized technique for investigating opinions, attitudes, and intentions, which it is essential to quantify if one is to understand as important a subject as repeat prescribing, which, in our study and the two others we cite, accounted for between 64 and 72% of all prescriptions issued by GPs. Secondly, we then explain the weakness of the semi-structured questionnaire, and the rest of the discussion section, which gives your correspondents such trouble, consists of as balanced and honest an interpretation of our tables and figure as we could produce. This involves, inevitably, informed value judgements based on the authors' 18 years' experiences observing, researching, and intervening in GP prescribing.

We agree that our statements are indeed alarming and should galvanize the profession to review its management of repeat prescribing. We firmly believe that, if the correspondents carefully re-read our article, with particular reference to the four tables, they will revise their opinion.

In showing the highly statistically-significant difference between the quality of repeat prescribing management in fundholding and non-fundholding practices, we have used statistics to show the validity of our repeat prescribing scoring table, and a mean score of 18 out of a possible 26 for the better repeat prescribing managers would give administrators, patients, and, we hope, our colleagues cause for both alarm and concern.

The correspondents may be interested to know that, in a follow-up study of 21 400 GP/patient encounters over a two week period in 22 practices, the following BNF anatomical drug categories were significantly associated with repeat prescribing frequency: gastrointestinal drugs, cardiovascular drugs, central nervous system drugs, metabolic drugs, dressings and appliances ($P < 0.0001$). These anatomical groups contain many drugs requiring the most careful surveillance in their use, and, in Table 4 of our article, the mean intervals between reviews for drugs in these

groups almost certainly reflect suboptimal management.

Finally, we have had over 30 requests for our repeat prescribing guidelines, from every part of Great Britain, each of them stating that our article had raised sufficient concern for the practice to wish to audit and improve its repeat prescribing.

HUGH MCGAVOCK
KEITH WILSON-DAVIES
PAUL CONNOLLY

55 Culcrum Road
Cloughmills
County Antrim
Northern Ireland
BT44 9NJ

References

1. Cubitt T, de Quincey M. Repeat prescribing management – a cause for concern? [Letter.] *Br J Gen Pract* 1999; **49**: 580.
2. McGavock H, Wilson-Davies K, Connolly JP. Repeat prescribing management – a cause for concern? *Br J Gen Pract* 1999; **49**: 343-347.

Nursing home residents: demands on GPs

Sir,

The paper by Pell and Williams (July *Journal*)¹ and brief report by Carlisle (August *Journal*)² have measured the increased workload many GPs feel to be associated with the care of patients in nursing or residential homes. They both found substantially increased patient contact with the GP. These patients also cost more in other areas.

In our practice, where we look after six times the national average of nursing home patients, we compared the mean drug expenditure for the 35 patients we look after in one nursing home with the mean expenditure for the whole practice. The drug bill per patient was over 13 times the practice mean, being in excess of £1000 per patient per year (1997).

Increased patient contact and drug use also increases practice administration.

The workload and drug expenditure is likely to get worse with patients becoming increasingly dependent when entering long-term residential care.

We wholeheartedly agree with the conclusions of Pell and Williams, and Carlisle, that the present capitation fee does not adequately reflect the workload involved in looking after patients residing in nursing homes. These vulnerable patients deserve to be looked after by GPs with the incentives and the resources to do so. Their GPs have provided care without adequate reward for too long; they too deserve better.

PATRICK M CRAIG-MCFEELY
JOHN R SEDGWICK
SUZY HOLDEN

Hillbrow Surgery
Liss
Hants GU33 7LE

DAVID J BERRY

Newtown Surgery
Liphook
Hants GU30 7DR

References

1. Pell J, Williams S. Do nursing home residents make greater demands on GPs? A prospective comparative study. *Br J Gen Pract* 1999; **49**: 527-531.
2. Carlisle R. Do nursing home residents use high levels of general practice services? *Br J Gen Pract* 1999; **49**: 645-646.

Child health surveillance

Sir,

I was interested to read of the effectiveness of child health surveillance in detecting key physical abnormalities (*August Journal*),¹ but, as far as I'm aware, no one has so far addressed the questions we raised in 1984 when our smaller audit demonstrated that a large proportion of boys were being detected late (average ages = 7.7-9.3 years at operation) with undescended testes, despite passing earlier checks including paediatric outpatient reviews.²

We questioned then whether some operations were being carried out unnecessarily, or whether previously descended testes could later become maldescended. Perhaps with our new child health surveillance programme we have solved the problem, or is there still a large proportion of boys having late orchidopexy?

TONY BOGGIS

Newlands Medical Centre
Borough Road
Middlesbrough TS4 2EJ

Reference

1. Hampshire AJ, Blair ME, Crown NS, *et al.* Is pre-school child health surveillance an effective means of detecting key physical abnormalities? *Br J Gen Pract* 1999; **46**: 630-633.
2. Boggis ARJ, Rowlatt RJ. A study of the sources of delay in the diagnosis and treatment of undescended testicle. *J R Coll Gen Pract* 1984; **34**: 440-441.

Motivational consulting

Sir,

Butler *et al* (*August Journal*)¹ rightly point out that smoking remains a serious public health issue and that more effective interventions are necessary. Unfortunately, their randomized trial falls short of providing the evidence needed to introduce motivational consulting as a health promotion tool in relation to smoking. We believe that biochemical validation of quitting is important.

The presence of a sub-group, among self-reported non-smokers, with concentrations of smoking markers suggestive that they are, in fact, smokers has been well reported.^{2,3} In a study to measure markers of tobacco smoking in patients with coronary heart disease, we found 4% of the total study group to be 'smoking deceivers'.⁴ We therefore believe that self-reporting of quitting for 24 hours and smoking abstinence for one month without biochemical validation are not reliable outcome measures and do not provide accurate evidence on which to base consulting practice. Markers of tobacco smoking, such as urinary cotinine, should have been included in the outcome measurements. Cotinine measurements are well established as the most sensitive and specific marker of tobacco smoking. The elimination half-life of cotinine, however, is in the region of 20 to 40 hours, which would negate its role as a marker for 24-hour quitting, but breath carbon monoxide should, in this case, have been a simple and effective measurement.

AGNES MCKNIGHT
MARGARET CUPPLES

Department of General Practice
Queen's University Belfast
Dunluce Health Centre
1 Dunluce Avenue
Belfast BT9 7HR

G P R ARCHBOLD

Clinical Chemistry
Gardner Robb House
Belfast City Hospital
Lisburn Road
Belfast BT9 7AD

References

1. Butler CC, Rollnick S, Cohen D, *et al.* Motivational consulting versus brief advice for smokers in general practice: a randomized trial. *Br J Gen Pract* 1999; **49**: 611-616.
2. Woodward M, Tunstall-Pedoe H. An iterative technique for identifying smoking deceivers with application to the Scottish Heart Health Study. *Prev Med* 1992; **21**: 88-97.
3. Wagenknecht LE, Burke GL, Perkins LL, *et al.* Misclassification of smoking status in the CARDIA study: a comparison of self report with serum cotinine levels. *Am J Pub Health* 1992; **82**: 33-36.
4. Archbold GPR, Cupples ME, McKnight A, Linton T. Measurement of markers of tobacco smoking in patients with coronary heart disease. *Ann Clin Biochem* 1995; **32**: 201-207.
5. Benowitz NL, Jacob P. Nicotine and cotinine elimination pharmacokinetics in smokers and nonsmokers. *Clin Pharmacol Ther* 1993; **53**: 316-323.

Primary care research

Sir,

Kendrick and Jones (*August Journal*)¹ bemoan the poor performance of academic departments of general practice in the 1996 research assessment exercise and suggest moving the goal posts as one solution.

There is no doubt that the development of general practice as an academic discipline has been critical for the development of the primary care agenda, but things move on. My colleagues and I have argued that the world of commissioners and providers of care provide a more realistic perspective for NHS primary care research² — refocusing the research agenda away from departments of general practice to an approach in which researchers, commissioners, producers, and patients are more closely aligned.

There is a need for universities to provide their primary teaching functions and chronicle the evolving canon. But for academic researchers, the goal posts don't need to be moved — the size of the team needs to start winding down.

D P KERNICK

St Thomas Medical Group Research Unit
Cowick Street
Exeter EX4 1HJ

References

1. Kendrick T, Jones R. Primary care research: moving on from the 1996 assess-

ment exercise. [Editorial.] *Br J Gen Pract* 1999; **49**: 603-604.

2. Kernick DP, Stead J, Dixon M. Moving the research agenda to where it matters. Its time to rattle the academic cage in primary care. *BMJ* 1993; **319**: 206-207.

Living wills

Sir,

Collins *et al* (August *Journal*)¹ highlight an issue the British Medical Association (BMA) has been struggling with for many years — how to make doctors aware of the ethical and medico-legal guidance that exists.

The choice of the BMA's code of practice on advance statements, to illustrate the lack of awareness of such guidance among GPs in Scotland, emphasizes the extent of the problem, since we have made particular efforts to publicize that document. Following a call at our annual meeting for more debate on the subject, 13 000 summaries of guidance — together with details of how to obtain the code of practice — were circulated with the *Journal of the Royal College of Physicians*. We also undertook an intensive series of talks on the subject around the UK. This is in addition to our usual multiple copies of the code for review in medical journals.

Our experience of sending material directly to doctors has been far from encouraging; partly because they are inundated by such mailings from a variety of sources. All GPs in the country, for example, have received at least one copy of the leaflet *Confidentiality and People under 16* by direct mailing, yet we regularly receive enquiries from GPs who have no knowledge of it. We never envisaged, therefore, a direct mailing of the advance statements code of practice, although a free summary is available on request.

The problem may be that the relevance of the guidance is not recognized until a situation arises in which that guidance is needed. The best we can hope for is that doctors know where to find information when they need it. If doctors are aware that they can contact the BMA or look on the website (www.bma.org.uk) for guidance on ethical and medico-legal matters, the fact that they do not have a comprehensive knowledge of all of the guidance the Association produces is less important. If all the 39% of GPs who knew of the BMA's code of practice were among the 43% whose patients had enquired about living wills, this can be seen as progress.

MICHAEL WILKS

British Medical Association

BMA House
Tavistock Square
London WC1H 9JP

Reference

1. Collins K, Lightbody P, Gilhooly M. Living wills: a survey of the attitudes of general practitioners in Scotland. *Br J Gen Pract* 1999; **49**: 641-642.

Encouraging GPs to write scientific papers

Sir,

Tim Albert's article (August *Journal*; Back Pages)¹ struck a cord. I am a GP locum and have, over the past year, been involved in setting up a multidisciplinary, web-based, distance-learning programme for healthcare professionals: www.hqh.org.uk

Our Healthcare Quality website has cost me and my colleagues £20 000 to produce. The additional cost of £500 for GP distance learning PGEA approval for the first year and £300 for annual renewal is an irksome disincentive to the provision of innovative professional development material.

The situation for Nursing CPD is different. The UKCC puts the onus on the individual to demonstrate that the educational material they have used meets their educational needs. Their system more closely matches the requirements of clinical governance.

JOCK RAMSAY

Healthcare Quality Limited
15 Cameron Avenue
Balloch
Inverness IV2 7JT

Reference

1. Albert T. Encouraging GPs not to write scientific papers... [Back Pages.] *Br J Gen Pract* 1999; **49**: 679.

Reducing antimicrobial resistance in Spain

Sir,

We read with interest the paper written by Lindbæk *et al* (June *Journal*)¹ about antibiotic prescribing and resistance rates in Norway, and we would like to complete that information with our experience and the judicious policy carried out with antibiotic use in Spain, where the resistance rates are probably the highest in Europe.

It is true that the proportions of multi-resistant pneumococci and resistant *Haemophilus influenzae* were steadily increasing during the 1980s, but these

have been constant over the past years, now comprising up to 40% that are resistant towards penicillin. Fortunately, intermediately resistant strains of *Streptococcus pneumoniae* account for 25 to 30% of all, and only 10 to 15% of pneumococcal strains isolated from hospital samples of invasive infections can be considered as resistant.² Therefore, Spanish guidelines recommend the use of third-generation cephalosporins for pneumococcal meningitis, but, for less life-threatening infections such as otitis media of sinusitis, it remains appropriate to use standard dosages of the commonly used antipneumococcal antibiotics like amoxicillin.³ However, the appropriate follow-up of the response to the therapy is important and, if no significant improvement within the first 48 hours of therapy is observed, the presence of a resistant germ should be considered.

Approximately 25 to 40% of invasive isolates of *Haemophilus influenzae* in Spain are no longer susceptible to penicillin or third-generation cephalosporins. For that reason, in those infections where this germ is suspected to be present, a penicillin β -lactamase combination is required. *Moraxella catarrhalis* has developed a considerable resistance to antibiotics, but this is not clinically important in Spain because it is susceptible for fewer than 2% of respiratory tract infections. On the other hand, *Streptococcus pyogenes* is yet completely susceptible against penicillin.

As mentioned before, resistance rates are currently the same as they were 10 years ago or have slightly dropped. In order to achieve this goal, some actions to protect patients from antimicrobial resistant infections have been carried out during this decade. First, antibiotic prescribing has strongly decreased in Spain recently. Antibiotic consumption in 1997, in terms of average numbers of defined daily doses (DDD) per 1000 inhabitants per day, was 17.6 in Catalonia; lower than the reported DDD in 1990 (24.5).

General practitioners, health administration, and scientific societies share common goals that can be of mutual benefit in preventing and controlling antimicrobial resistance. For instance, the Catalan government has developed clinical aids such as clinical guidelines for GPs and educational brochures for patients. Patients often require an explanation that antimicrobials offer no benefit for their viral infection and may even be harmful. This phenomenon is very important; approximately 50% of unnecessary prescriptions on antimicrobial agents for upper airway infections are still written.⁴

The Catalan Society of Family

Physicians assists clinicians by providing judicious guidelines and surveillance summaries of local resistant patterns. Some prescribing patterns are recommended, such as prescribing less broad-spectrum antibiotics in primary health care. Amoxicillin/clavulanate potassium is considered as the drug of choice in only a small percentage of infections; i.e. for the respiratory superinfection in patients with chronic obstructive lung disease, where *Haemophilus influenzae* is the leading infectious agent. We also recommend not using antibiotics for the common cold and simple coughs, and not to prescribe antibiotics for sore throats unless *Streptococcus pyogenes* is suspected to be present by means of clinical parameters. We recommend also, to limit antibiotic prescription for uncomplicated cystitis to three days in healthy women, to not prescribe no antibiotics for initial treatment of acute bronchitis and otitis media with effusion, and to prescribe amoxicillin as the drug of choice for acute sinusitis, acute otitis media, and pneumococcal pneumonia.

To summarize, improving prescribing practices and consequently decreasing the spread of antimicrobial resistance can be accomplished in places where, unfortunately, resistance rates are very high. Additional actions can be taken like limiting the sales of antibiotics at the pharmacy without a medical prescription. A judicious prescription of antimicrobials is therefore essential to maximize the life of existing classical drugs such as amoxicillin, which is recommended as the antimicrobial of choice for most infections observed in primary health care and currently accounts for 52.5% of all the prescriptions written.

CARL LLOR

MIQUEL ANGEL MAYER

Catalan Society of Family Medicine
Catalan
Spain

References

1. Lindbæk m, Berild D, Straand J, Hjordahl P. Influence of prescription patterns in general practice on antimicrobial resistance in Norway. *Br J Gen Pract* 1999; **49**: 436-440.
2. Latorre C, Sierra M, Lite J. Estudio prospectivo de las cepas invasivas de *Streptococcus pneumoniae* aisladas en 16 hospitales de Cataluña durante 1996. [Prospective study of the invasive strains *Streptococcus pneumoniae* isolated in 16 Catalan hospitals in 1996.] *Enferm Infecc Microbiol Clin* 1999; **17**: 286-291.
3. Schwarzmann SW. Novel cost-effective approaches to the treatment of community-acquired infections. *Ann Pharmacother* 1998; **32**: S27-S30.

4. Romero J, Rubio M, Corral O, *et al.* Estudio de las infecciones respiratorias extrahospitalarias. [Survey of respiratory tract infections in primary health care.] *Enferm Infecc Microbiol Clin* 1997; **15**: 289-298.

Data management in primary care

Sir,

In 1998, the University of Liverpool Department of Primary Care conducted a pre-transition pilot study before the mandatory change to CFC-free inhalers for asthma patients.¹

Twenty-eight GP training practices were approached; six agreed to participate, comprising 26 GPs and an average practice population of 8500 patients. Information was collected by practice staff with a researcher present.

Information requested was as follows:

- Current and acquiescent asthmatics,
- Patients using metered dose inhalers (MDIs),
- Numbers attending nurse-led asthma clinics,
- Number of hospital admissions for asthma.

After a considerable amount of effort, three practices produced complete data: one practice produced no data over a year and two produced incomplete data. The reasons were that staff (both professional and clerical) in the practices did not know how to retrieve information from the systems, and non-standardized data entry made the task of information retrieval extremely difficult.

Two practices combined chronic obstructive pulmonary disease and asthma patients under a 'respiratory' code; therefore, asthma patients alone could not be identified. Numbers for current and acquiescent asthmatics were not readily available in any of the practices. Patients on MDIs were identified by searching all respiratory drug lists or individual patient records.

Asthma clinic data failed to reflect the work of the asthma nurse. Computer records in one practice recorded 212 patients seen in clinics in one year. A further 111 follow-up visits were identified through manual searching for the same year. This represents an additional 52% of the initial estimate. No practices maintained computer records of hospital admissions for asthma. Figures ranged from 'best estimates' to unknown.

There are a number of concerns highlighted in this pilot study. The low response rate (21%) indicates that even training practices have a limited interest in

clinical audit. A disorganized approach to data management and a general lack of knowledge of the systems were apparent for all staff. Data for nurse-led asthma clinics showed less than 50% of patients were regularly seen in four out of the five practices. This questions the viability of asthma clinics as an efficient use of resources.

Computerized systems were not used efficiently. Their value was limited by inadequate training for all practice staff. In terms of this particular project, standardized procedures for data coding, entry, or analysis were not evident, and the potential of the systems were never developed or used.

A RANNARD

J BOGG

P BUNDRED

Department of Primary Care
University of Liverpool
Whelan Building
Quadrangle
Brownlow Hill
Liverpool L69 3GB

Reference

1. United Nations Environment Programme Technology and Economic Assessment Panel of the Montreal Protocol on Substances that Deplete the Ozone Layer. Part 111. *Update of the 1994 TOC Aerosols Report and the MDI Transition Strategy*. London: TEAP, June 1996.

Clinical skills assessment

Sir,

The three letters (August *Journal*)¹⁻³ commenting on our article, 'Clinical skills assessment',⁴ provide a spectrum of opinion, and we would like to take the opportunity to respond.

On the one hand we have Hartnell,¹ who talks about gold standards when the paper is concentrating on the trainer's report, which is a component of summative assessment: a test of minimal competence. The marking plan was lifted directly from the content of the trainer's report⁵ and was the basis of the study.

The letter from Rhodes² appears to be in broad agreement with the messages of our paper and, although recognizing the limitations of the 'dummies', he should realize that these doctors were at the end of their training and were tested on mannequins with a gross abnormality and a clinical scenario to help in their decision-making. Unfortunately, he loses the thread of his argument by again berating the summative assessment process, quoting

unpublished material, when the paper only deals with one component of this four-part process.

The third letter from Johnson,³ who developed the trainer's report, recognizes the value of the paper and further work in this area.⁶ Our paper not only highlights deficiencies on the trainer's report but also the deficiencies in the way in which it is used by trainers. It also raises doubts over the quality of assessment of senior house officers in the hospital setting and the validity of the signature on the VTR2.

MOYA H KELLY
T S MURRAY

Department of Postgraduate Medicine
West of Scotland Postgraduate Medical
Education Board
1 Horselethill Road
Glasgow G12 9IX

References

- Hartnell V. Clinical skills assessment. [Letter.] *Br J Gen Pract* 1999; **49**: 662.
- Rhodes M. Clinical skills assessment. [Letter.] *Br J Gen Pract* 1999; **49**: 663.
- Johnson N. Clinical skills assessment. [Letter.] *Br J Gen Pract* 1999; **49**: 663.
- Kelly MH, Campbell LM, Murray TS. Clinical skills assessment. *Br J Gen Pract* 1999; **49**: 447-450.
- Johnson N, Hasler J, Toby J, Grant J. Consensus minimum standards for use in a trainer's report for summative assessment in general practice. *Br J Gen Pract* 1996; **46**: 140-144.
- Johnson N, Hasler J, Toby J, Grant J. Pilot testing of a structured trainer's report for summative assessment in general practice. *Educ Gen Pract* 1997; **8**: 308-315.

Simulated surgery

Sir,
Fraser and McKinley (September *Journal*)¹ challenge the validity of the simulated surgery as an assessment of consulting skills in their letter. Their grounds include the omission of diagnostic skills, not testing detection of abnormal physical signs, and the inability to portray children, emergencies, and previously known patients. These exclusions were quoted from our paper² and are freely admitted as a limitation of the methodology. However, since the validity of a test is the extent to which it measures what it purports to measure, and not some other attribute of candidates, we would maintain that it is a highly valid instrument for the skills that it examines.

Diagnosis consists of data gathering and pattern matching with a set of known conditions to produce a label for the patient's illness. The former is fully exam-

ined in the simulated surgery, but the latter is a problem-solving skill that is exercised in the doctor's mind, and only the outcome can be observed in the consultation. The process of diagnosis is better examined in written or oral tests (such as Paper 1 and the MRCGP oral), in which the candidate can be asked to justify his/her reasoning. It can be covered in an OSCE by including a pencil and paper task in alternate stations, as in the Canadian LMCC. However, this interrupts the flow of what is intended to be a normal surgery for the candidate; also, as mentioned in the paper, a mistaken diagnosis invalidates the marking criteria for communication, management, and anticipatory care in the rest of the case.

The detection of abnormal physical signs requires a set-up similar to the surgical short cases in the final MB examination, which all GP registrars will presumably have passed. Arguably, this skill is not contributory in the majority of general practice consultations. The simulated surgery does examine the ability of the candidate to carry out a competent and relevant physical examination that would detect any abnormal signs that might be present. Courtesy, communication, and respect for the patient's dignity are also examined during physical examination. Video methods are unable to assess competence in a physical examination that takes place 'off camera'.

The exclusion of children and emergencies is being addressed: the most recent round of the examination included a 12-year-old asthmatic child, role-played very capably by four enthusiastic boys; plans are in hand for a new station in which the candidate has to give emergency advice to

a patient on the telephone. No other examinations to our knowledge have addressed this growing area of consulting skills in general practice.

Finally, while it is clearly impossible to include patients previously known to the candidate in the simulated surgery, information on past history is provided in the records, and candidates need to use it in their consultation. The presentation of 'new' patients with information in their records is probably more familiar to GP registrars than to their established trainers.

PETER BURROWS
LIZ BINGHAM

Abbey Mead Surgery
Romsey
Hampshire

References

- Fraser RC, KcKinley RK. Simulated surgery. [Letter.] *Br J Gen Pract* 1999; **49**: 753.
- Burrows PJ, Bingham L. The simulated surgery – an alternative to videotape submission for the consulting skills component of the MRCGP examination: the first year's experience. *Br J Gen Pract* 1999; **49**: 269-272.

Correction

The August issue of the *Journal* contained an error in the second paragraph of the editorial by Tony Kendrick and Roger Jones, entitled 'Primary care research: moving on from the 1996 research assessment exercise'. The range given in line 8 of the paragraph should read "...from 1 (worst) to 5* (best)", and not "...from 1 (worst) to 7 (best)". We apologize for any confusion caused by this error.

Correction

In the January issue of the *Journal* there were a number of errors in Table 2c in the paper by Kevork Hopayian and Miranda Mugford, entitled 'Conflicting conclusions from two systematic reviews of epidural steroid injections for sciatica: which evidence should general practitioners heed?' We apologize for the errors and reproduce here the correct version of the table, with our sincere apologies to the authors for the delay in the publication of this correction.

Table 2c. Ranking of common papers according to methodological quality.

Study	Score	
	Koes et al ⁹ (maximum score = 100)	Watts and Silagy ⁷ (maximum score = 9)
Snoek ¹⁹	72	9
Mathews ¹⁸	67	9
Breivik ¹⁷	63	9
Cuckler ¹⁶	62	7
Bush ²⁰	59	9
Klenerman ²²	50	9
Dilke ²¹	50	9
Ridley ²⁸	47	8
Beliveau ²⁹	45	3
Yates ¹⁵	17	0