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.

Supporting practice-based audit

Sir,

Lough *et al* (October *Journal*)[1] demonstrate well the massive time investment that is required for manual extraction of data for practice-based audit. With the maturation of Miquest interpreters and GP clinical systems, such effort is rendered unnecessary.

At Saffron Group Practice we have a system of computerised annual audit that covers seven chronic diseases and health promotion. Using Lough *et al*'s figures, I estimate that it would take a full-time worker (at 37.5 hours per week) over 19 weeks to extract the data described for our practice, not including the time for analysis. Using a suite of home grown Miquest queries and spreadsheets, we are able to extract considerably more detailed data than that described, without sampling, and analyse and present it in a meaningful form in about 30 minutes. This is roughly 1500 times faster than a manual system. The data is available to the practice on the day of the audit. Data input costs have virtually been eliminated as data collection is integrated into routine patient care.

Health authorities considering investment in audit would be well advised to invest in clinical system training for primary care teams. This would have a number of beneficial spin-offs, including the more rapid introduction of the electronic patient record, with its better data access for clinicians and the possibilities of decision support and prompting of care. It would open up the rich GP database for research, needs assessment, and audit.

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Reference

1. Lough JRM, Willmot M, Murray TS. Supporting practice-based audit: a price to be paid for collecting data. *Br J Gen Pract* 1999; **49:** 793-795.

The reform of GP training

Sir,

I was interested to read Dominic Faux's proposals for reform of GP training (October *Journal;* Back Pages).[1]

In fact, the 'senior registrar' post he proposes is already in existence in Sandwell Health Authority. It has been brought about through collaboration between the health authority, LMC, and training practices in the area.

In addition, there are many similar schemes up and down the country, such as Career Start in County Durham, and the South London Vocationally Trained Associate scheme. Having reviewed the literature on such schemes, however, I believe that the Sandwell scheme is the only one that incorporates all the elements Dr Faux describes.

If the College wants to support the development of such schemes, as many believe it should, I propose that the first step should be to develop an accreditation package. This will not only support and set clear standards for those developing and administering such schemes, but will form the first step towards formalising the higher professional training of GPs.

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Reference

1. Faux D. Training GPs – a counterblast to the status quo. [Back Pages.] *Br J Gen Pract* 1999; **49:** 849.

Providing health care for the homeless

Sir,

Hewett's article on providing primary health care for homeless people from the perspective of the homeless (October *Journal*)[1] was interesting and a welcome addition to the limited literature on homelessness and primary health care. However, by adopting a quantitative approach, he appears to have achieved only a simplistic understanding of homeless people's views. The findings of his structured questionnaire study showed that, while the options of facilitated access to mainstream primary health care and special provision for homeless people were both endorsed, 36% of responders had personally experienced difficulty with registering with a GP and 84% of responders preferred a specialist homeless medical service. However, the study failed to access underlying reasons for these views about primary care provision, reducing the utility of such work in planning future medical services.

Attempting to explain the findings of the questionnaire, Hewett suggests that poor access to health care may be because homeless people may be reluctant to register with a 'mainstream' practice because of expectations of refusal. In contrast, Shiner, using a qualitative approach to explore the same question, interviewed 16 people sleeping rough in detail about their attitudes to health and use of primary care services. He found that homeless people did not place a low priority on their health but in fact made rational decisions about seeking help based on what they felt it was realistic to expect given their circumstances.[2] Hinton, using in-depth interviews with day centre attenders, also found that homeless people were not uninterested in promoting their own health but were realistic about their ability to have an impact on it.[3]

Such findings, I would suggest, highlight the need both to raise homeless people's expectations of mainstream primary care and to support mainstream providers in this work, rather than increasing the provision of potentially marginalising specialist health provision. It is of course important to discover what homeless people in Leicester think, but if research is to effect positive change in service provision, it is equally important to understand the reasons behind the statistics.

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1. Hewett N. How to provide for the primary health care needs of homeless people: what do homeless people in Leicester think? *Br J Gen Pract* 1999; **49:** 819.
2. Shiner M. Adding insult to injury: homelessness and health service use. *Sociology of Health and Illness* 1995; **17:** 525-549.
3. Hinton T. *The icing on the cake: a review of health promotion initiatives for single homeless people on the North Thames region.* London: Health Action for Homeless People, 1997.

The future for non-principal GPs

Sir,

Shakespeare and Evans (November *Journal*)[1] helpfully point out many of the problems faced by non-principal GPs. However, they make no specific mention of revalidation,[2] which the General Medical Council intend to introduce for all doctors in the UK by 2002. Non-principals and others in 'non-standard' careers will need revalidating, but the practicalities need to be carefully considered. Current models[3] may be difficult to apply to locum doctors.

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1. Shakespeare J, Evans J. The future for non-principal general practitioners: Lost doctors – lost to whom? *Br J Gen Pract* 1999; **49:** 868-869.
2. Buckley G. Revalidation is the answer. *BMJ* 1999; **319:** 1146-1147.
3. Southgate L, Pringle M. Revalidation in the United Kingdom: general principles based on experience in general practice. *BMJ* 1999; **319:** 1180-1183.

Recruitment and retention of GPs in the UK

Sir,

The Medical Practices Committee (MPC) wishes to respond to the article by young and Leese regarding the recruitment and retention of GPs in the UK (October *Journal*).[1]

While there is much in the article that the MPC fully recognises and with which it would readily agree, there are a number of points to be made. Primarily, the Committee's concern is that, because of the long gap between the submission of the articles and the publication, the research appears incomplete and out of date. For example:

- GMS statistics published by the Department of Health are available for the years up to 1998, but the article refers only to changes up to 1996 (the data for 1998 has been available since May 1999),
- The MPC has undertaken a survey of GP recruitment each year since 1994, but reference is made to the 1995 survey only (the 1998 survey has been available since October 1998).

This time focus is particularly important, as recent years have seen many significant developments. The Primary Care Act Pilot Schemes and Primary Care Groups referred to in Leese and Young's conclusions are in fact already in place. The continuation of several important trends beyond the 1996 GMS data also shows that opportunities for female GPs and part-timers have continued to expand and, at the same time, the MPC's Surveys of Recruitment have shown that there has been no worsening in the recruitment position. The time taken to recruit, the number of applicants per advertised vacancy, and the quality of those applicants have remained largely unchanged.

This is not to suggest that the MPC is in any way complacent about the future of the GP workforce and the services provided. The Committee shares the concerns raised about the consequences of increased part-time working (more new entrant GPs required), readily accepts that there urban and rural areas where recruitment is more difficult than elsewhere, and certainly recognises that a wide range of forces impact upon society's demands and the GP workforce's ability to respond. The Committee would, however, contend that many aspects of the situation described in the article have changed considerably since the period upon which the authors focussed, and that further work should take this into account.

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Reference

1. Young R, Leese B. Recruitment and retention of general practitioners in the UK: what are the problems and solutions? *Br J Gen Pract* 1999; **49:** 829-833.

The need for an e*BJGP*

Sir,

I was most interested in the letter from Thompson about the need for an e*BJGP* (November *Journal*).[1]

As an informatics tutor in North Trent, I am often asked about the availability of full text in online journals. Most GPs are puzzled when they can get a reference off MEDLINE but cannot get the full text, as they fail to see the reasons that prevent electronic publication.

The demand for the full text online version is certainly out there. In a recent survey of nearly 500 of the members of Doctors.net.uk asking which journals they would like to see available online, the *BJGP* was the most requested general practice journal (personal communication: R Kane, 1999).

One particular point Thompson did not mention was the wider access to the *Journal* that could occur when NHSnet becomes widespread. This will roll out Internet access to every general practice desktop in the National Health Service within a year or so, allowing many more general practitioners to take advantage of the *Journal*'s research if it is made available online.

Online learning in the newly wired National Health Service is the way ahead, don't let the *BJGP* be behind!

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Reference

1. Thompson T. The need for an e*BJGP*. [Letter.] *Br J Gen Pract* 1999; 49: 924.