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Reciprocity

I have recently been informed that the RCGP is terminating its reciprocity agreements with the equivalent colleges in Australia, New Zealand, South Africa, Canada, and the USA. This agreement enabled members of the various colleges and boards to sit each other's examination. To RCGP members living and working overseas this provided a means of gaining recognition from an overseas body without having to repeat GP training or its equivalent.

I live and work in the USA and planned to sit the American Board of Family Practice examination at the next sitting. Now I will have to complete a further three years of residency training before I can do so. In my case this has caused havoc. Not having Board Certification will restrict where I can become licensed in the USA and will have a significant impact on my career. I imagine other doctors working abroad wishing to use this agreement will have similar problems. This decision would seem somewhat short-sighted and strategically wrong for the RCGP.

Ironically, the College appears to have a better reputation abroad in some quarters than it does in the UK and terminating this agreement may take away from its standing. Like many doctors overseas I am proud of my membership of the College and of its achievements and contribution to family health. However, I simply don't see how this decision helps with improving relations with overseas family practice organisations. I understand there has been considerable discussion and wide consultation of this decision, although as a member living overseas I only heard of it after the event and I don't recollect it being discussed within the pages of the *Journal*. I think the very least the College could have done was to give a year or two's notice of the ending of these arrangements to enable those of us living overseas to deal with this in a reasonable timeframe.

I realise there is difficulty in assessing training overseas, however I feel this is a bad decision and it arguably sends a

message to the affected colleges and boards overseas that the RCGP doesn't trust their training and assessment procedures. Surely there was, and is, a better way.

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In response...

I appreciate and understand the difficulty that the termination of the reciprocity agreement with the American Board of Family Practice has caused for Dr Kieran Smart. However, the College has not had reciprocity agreements with Australia, New Zealand, South Africa, and Canada. In fact, it has not had an agreement for recognition of the UK and USA qualifications to practice in each other's countries. The agreement with the American Board of Family Practice was simply to allow candidates to sit each other's examinations without undergoing additional training if they had been successful at a previous date in their national post-graduate qualification for family medicine.

The College considered the issue of reciprocity in great detail earlier this year. This was initially undertaken by the International Committee and then by both the College Executive Committee and Council. It was decided for the following reasons that it would be difficult to agree to and maintain reciprocal agreements in the foreseeable future:

1. The need to develop rigorous and clear criteria for reciprocity.
2. The need for these criteria to be applicable to all countries throughout the world and not just to those of the Commonwealth.
3. The fact that in most countries post-graduate assessments for family medicine undergo frequent changes and therefore it would be necessary to undertake a regular monitoring of any such agreement.
4. The fact that such monitoring of agree-

ments would require considerable financial and personnel resources by the College.

We are aware that the Australian College has approved unilaterally a limited recognition of MRCGP in order to encourage UK doctors to practice in rural and inner-city areas in Australia that are under-doctored. We appreciate that a small number of College members overseas and members of sister colleges overseas will be disadvantaged by our decision and regret that this is the case.

PHILIP EVANS

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Decline in 'ordinary' GP authorship in BJGP continued in the 1990s

Pitts¹ noted the proportion of first authors of *BJGP* papers from mainstream UK GPs fell from one-half to one-third between 1980 and 1989 and feared the *Journal* may become irrelevant to the 'ordinary' GP. Since then, R&D (Culyer) funding² has been made available to grassroots GPs to increase collaboration with other health and non-health professionals. Academic general practice has expanded. Though often underdeveloped,³ it has a core function to support service GPs.⁴ I hand-searched all original papers (including brief reports but excluding discussion papers and review papers) the *BJGP* published in 1990 and 1999 to compare characteristics of authors and their extent of collaboration with other professionals.

I identified 79 and 130 published papers in 1990 and 1999 respectively. The proportion of papers with one, two, three, and more than three authors in 1990 (1999) was: 26.6% (3.8%), 24.1% (21.5%), 11.4% (24.6%), and 38% (50%) respectively. The mean number of authors per paper was significantly higher in 1999 (3.7) than in 1990 (3.11) (independent sample *t*-test, *P* = 0.03). The proportion of papers with one, two, three, and more than three professionals represented in 1990 (1999) was: 58.2%

(42.3%), 21.5% (34.6%), 15.2% (17.7%), and 6.3% (5.4%) respectively. The mean number of authors per professionals represented in 1990 and 1999 was 1.73 and 1.86 respectively (independent sample *t*-test, $P > 0.05$). There were no significant differences in the proportion of first authors from outside the UK in 1990 (10.1%) and 1999 (14.5%) ($\chi^2 = 0.88$, $df = 1$, $P > 0.05$). The occupations of the first authors are shown in Table 1. There were no significant differences in the proportions of first authors who were medically qualified in 1990 (79.7%) and 1999 (74.6%) ($\chi^2 = 0.72$, $df = 1$, $P > 0.05$). However, the proportion of service GP authors decreased significantly from 34.2% to 21.5% ($\chi^2 = 4.05$, $df = 1$, $P = 0.044$), while the proportion of academic GP authors increased significantly from 21.5% to 35.4% ($\chi^2 = 4.49$, $df = 1$, $P = 0.034$).

The trend for the declining proportion of 'ordinary' UK GP authorship in the *BJGP* has continued, with a corresponding increase from the academic departments. Does this reflect the ability of the academic departments to flourish in spite of considerable pressure or the failure of the recent initiatives to promote R&D in primary care? Do service GPs require more support from the academic departments? The effects of initiatives to encourage increased collaboration have been limited — only about one-quarter of the increase in the number of authors per paper represents involvement from other professionals.

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A vote of no confidence in the precision of the estimated cost-effectiveness of lipid lowering

The purpose of a confidence interval is to quantify the uncertainty surrounding the results of a study. Unfortunately, the method used to calculate the cost-effectiveness of lipid lowering by Hippisley-Cox and Pringle (September *Journal*)¹ ignores important sources of uncertainty and the reported confidence intervals may be misinterpreted.

By using the unadjusted number needed to treat (NNT) from the 4S study (with its reported confidence interval) the authors make the implicit assumption that the baseline risk is the same for their patients as for those in the 4S study and the benefit of treatment is also identical.

It seems to me that both of these assumptions are questionable. The authors acknowledge the differences between their patients and those in the 4S study but were unable to quantify the overall balance of risks. If they had been able to do so, the relative risk reduction from the 4S trial could perhaps have been applied to the baseline risk of the Nottinghamshire patients to obtain a new NNT. This approach has been advocated by other authors when applying data collected from meta-analyses.^{2,3}

A greater problem stems from the observation that the Nottinghamshire patients achieved a much smaller reduction in their lipid levels than in the 4S trial (21% compared with 38% for LDL cholesterol). This is likely to mean that the risk reduction for the Nottinghamshire patients is less than that in the 4S trial and no attempt is made to adjust the cost-effectiveness calculations to allow for this.

Since the confidence intervals reported do not take into account the uncertainty of differences in the baseline risk and reduced lipid lowering they are misleadingly narrow. Indeed, if the baseline risks were similar but the effects of treatment were in line with the reduction in LDL cholesterol achieved, the best estimate of the cost to prevent one coronary event would be around £31 000, which is above the upper confidence interval quoted.

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Hippisley-Cox and Pringle (September *Journal*)¹ express surprise that lipid-lowering drugs in their study were less effective than in 4S, with their patients achieving a 21% reduction in LDS cholesterol compared with 38% (actually reported as 35% in 4S).² Yet, of their 83 patients, 68% were taking fluvastatin 40 mg daily (expected to produce a 23% to 29% reduction in LDL),^{3,4} 28% were taking fenofibrate 200 mg daily (expected to produce about a 20% reduction),⁵ and only 4% were on simvastatin 20 mg daily (expected to produce about a 35% reduction).³ This compares with 4S where 37% of the patients took simvastatin 40 mg daily (expected to produce about a 41% reduction)³ and the remainder 20 mg daily. Their patients were unlikely ever to achieve the scale of reduction seen in 4S.

This highlights a dilemma for the general practitioner: what treatment strategy should be adopted? For instance, when presented with a patient with an LDL value of 5.91 mmol/l after diet (mean value reported in the authors' study) what biochemical objective should be aimed for — an LDL value of below 3 mmol/l or a reduction of about 33%? What about the choice of statin — one that has been shown to decrease mortality and morbidity⁶ or, accepting the class-effect theory, an alternative, less expensive statin? Should treatment begin with a low dose and titrate upwards if needed, or an appropriate dose of a statin that, in this instance, should provide the 49% reduction required to move from 5.91 down to below 3 mmol/l? Yet another challenge arising from the compelling cardiovascular benefits of statins.⁷

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Table 1. Occupation of first authors in papers published by the *BJGP*.

	1990	1999
Academic GP	17 (21.5%)	46 (35.4%)
Service GP	27 (34.2%)	28 (21.5%)
Other medically qualified clinicians	7 (8.9%)	15 (11.5%)
Researcher	19 (24.1%)	20 (15.4%)
Others	9 (11.4%)	21 (16.2%)

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In response...

Dr Cates's points are valid. Analyses such as these are not precise and are liable to errors either way. We only wished to give a broad estimation using best available data. In our discussion we did try to acknowledge the limitations regarding coronary risk estimates and the lack of sensitivity analyses.

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More statins and evidence-based careers

The *Journal's* debate on statins¹⁻³ contains barely a word on how to convey these risk analyses into meaningful information for patients.

Under trial conditions, is a number need to treat of 13 people with five years' treatment to prevent one event the same as a minimum annual failure rate of treatment of 98.7%? Real world results will be poorer. Many would wisely choose not to take tablets.

That would disappoint the managers and politicians who measure the lot of the individual hardly at all. In contrast to public health specialists, managers or politicians, the general practitioner has to support the

individual. Paradoxically, exercising personal informed choice is the most ethical way of limiting demand.

Statistics are abstract, a distillation of events that have happened to other people in other places. Statistics mislead many people into believing the future is certain, increasing the dilemma.⁴ Absolute, rather than relative, risk figures may allow patients to evaluate better the evidence. The blind application of clinical guidelines made up by people who, even to me, are strangers and who understand little, if anything, about the hopes, aspirations, and beliefs of the patient to whom these life strictures are applied, seems to me a prostitution of our art. Doubts over the value of dietary advice are a case in point. How much enjoyment has been diminished by the apparent dangers in the questionable⁵ belief that a single indiscretion will make a measurable difference?

The reasons for the problems within the profession with early retirement, poor recruitment, and morale⁶ may reflect a drift from the needs of the individual. A re-establishment of the job description 'providing personal, primary and continuing medical care to individuals and families' might help. This care delivery should be based, as ever, on the best information available (evidence-based practice). Responsibility (clinical governance) always rested clearly with the doctor and patient to reach a solution that best suits the individual, not the system. Only the nomenclature is new. Can we still provide an environment in which an evidence-based approach, with high levels of accountability, is compatible with duties to the individuals who entrust us to manage their care?

The scientists and the population are well represented. There are many individuals within the system who need guidance or protection from a didactic approach. The values and professional rewards that brought most of us into practice are diluted. Is avoiding, or leaving, a system under increasing pressure to ignore the wishes, beliefs, and ideas of the individual an inevitable moral decision?

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Bridging the divide — public health and primary care group

With primary care centre stage in the health agenda, and with one of the roles of PCGs/PCTs being to reduce health inequalities and improve the health of their local populations, there is a need to improve the mutual understanding of those working in primary and community care and those working in public health.

The National Public Health and Primary Care Group (PHPCG) is working to bridge the divide by promoting an understanding and knowledge of the public health role in primary care, and the primary care contribution to the public health role.

The group was started by a number of public health physicians interested in developing public health involvement in primary care following the 1990 reforms. This group now has representatives from a wide range of organisations, including the RCGP, RCN, HVDNA, and the CDA.

It works to further its aims in a variety of ways through networking and the promotion of a multi-agency and multidisciplinary approach to tackling health inequalities. The executive organises conferences, workshops, and focus groups. Topics have included health needs assessment, measuring general practice, priority setting, and information needs, which have been decided in consultation with other organisations, including the RCGP. An excellent guide to health needs assessment and choosing priorities for primary care groups has been produced (<http://www.geocities.com.hotspots/4202/index.html>). The PHPCG have also contributed to the last CMO's work on strengthening the public health function in primary care and the All Party Group on Primary Care and Public Health.

In addition, the group identifies areas for research or development. A survey of Directors of Public Health to assess the capacity and capability of public health departments to support PCGs has been undertaken, the results of which have recently been published.¹

Those working in primary care and the community will have a key role to play in

assessing health needs, meeting those needs, and targeting local inequalities. Membership of the PHPCG can support you in this, provide a pre-existing network of like-minded colleagues, and give you the opportunity to be influential in a crucial area of current and future practice.

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Direct current cardioversion

The recent paper by Houghton and colleagues (September *Journal*)¹ makes some interesting points but also raises some pertinent questions, which relate both to specialists' relationships with GPs and to the role of the *Journal* in promoting primary care research.

First, is it really new knowledge that duration of atrial fibrillation (AF) is a factor in determining the success of cardioversion? I remember being taught this in the dim and distant past as a medical SHO. Perhaps it needs to be stated that it is not worth referring patients who have been in AF for more than three months but that is not the message that comes across. Indeed, the results make depressing reading irrespective of duration. Thus, even in the best case scenario only 46% of patients remained in sinus rhythm at three months. It would be interesting to know what the success rate at 12 months was. For 54% of the patients with the best chance of successful reversion to sinus rhythm they have to go through a period of rhythm instability where the chances of thrombo-embolic complications are at their highest. This has serious implications for the role of anticoagulants, even for apparently successful cardioversions. The authors have not addressed this

point at all. I cannot, therefore, understand how the authors can state as their conclusion that 'general practitioners should not hesitate in referring these patients for cardioversion'. I think GPs should have every hesitation and should seriously question the role of cardioversion at all if the success rate is so low.

Given that the date of the study is not stated, it is likely to have been quite some time ago. This is also backed up by the finding of flecainide use in study participants. One must therefore question why and how a secondary care study with a misleading conclusion came to be published in a Royal College of General Practitioners publication.

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Editor's response

The *Journal's* editorial board has spent some time discussing the general policy on what papers should be published. The form of words that we have adopted, and which will shortly be publicised as part of a revised 'Information for Authors', is: 'It is an international journal carrying articles of interest to workers in general practice and primary care worldwide. Priority is given to research papers asking questions of direct relevance to the care of patients.' In other words, not whether the research is done by primary care workers but whether the results matter to primary care workers. In this case, the judgement was that it did. The judgement on originality has to be guided by the expert advice of the referees but with the rider that it would be wrong for the *Journal* only to consider publishing truly original papers. Such a policy would both prevent us accepting important confirmatory evidence and also force authors to make increasingly specious claims for the originality of their work. If this paper repeated a finding well established by previous work then we have erred; but neither David Fitzmaurice nor the referees produced the relevant evidence. As for the interpretations, I welcome David Fitzmaurice's alternative, which seems equally valid. As always, the answer would, in an ideal world, depend on the patient's personal values.

DAVID JEWELL

Editor

British Journal of General Practice

Evidence-based prescribing — time to issue condoms from general practice!

Two articles in the July *Journal* reminded me of our responsibility as general practitioners to continue to push for the availability of condoms from general practice as part of our armamentarium in the provision of sexual health services. It was interesting to read an east London survey on school students' attitudes to general practice provisions of sexual health care.¹ One in three thought free condoms were available from general practice. (Sorry, not unless they are lucky. Is this the message we want to give in promoting appropriate teenage health care?) Meanwhile, Leeds travel agents didn't advise young men off on a stag party to Amsterdam about safe sex and condoms.² Even if they or their peers travelling further afield had consulted their general practice, and if the message had been given, we would probably not have had the wherewithal to encourage them to practice what we preach.

I expect most people will continue to buy condoms but in primary care we need to be able to encourage safe sex and effective contraception, both in terms of discussion of technique and provision of supplies to people who for any reason, whether youth, self-consciousness, poverty or other priorities, are not accessing it yet themselves.

This summer was my first attendance at my Local Medical Committee annual conference and one of my, no doubt naïve, irritations was that the City and East London resolution of condom provision in general practice was not discussed. I am quite cynical about what governments deliver to the NHS but I have to admit to surprise and disillusion that during my 18 years in general practice, almost all within the AIDS era, while the term 'safe sex' has become core to the vocabulary of primary health care, condoms have not become routinely available from general practice. And where is the voice of general practice about this?

I've spoken to colleagues from several parts of the country and of those who have condoms available in general practice they only do so through short-term project or development funds. We had condoms in many Tower Hamlets practices through HIV monies years ago but they went when the funds were cut back, despite recommendations on teenage health. In a cash-strapped, teaching hospital-based, inner-city health economy, no further monies have been made available for general practice condom supplies.

Sex is not ephemeral. Free contraception for women was won as public policy through campaigns 30 years ago as a cost-effective measure for the state. It is time to extend this by implementing the evidence base for the condom as barrier to infection and pregnancy and have condom supplies to general practice as core provision. Well, colleagues?

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Aromatherapy again

In their recent review on aromatherapy, Cooke and Ernst state that much of the primary data has 'methodological flaws'.¹ Interestingly, the complaint of 'methodological flaws' can also be levelled at Cooke and Ernst's review.

Much of their paper goes against established principles of systematic review. No focused research question is stated. There are arbitrary eligibility criteria, such as that excluding studies on 'local effects' and these are inconsistently applied: a trial of tea tree oil for athlete's foot is excluded,² whereas a trial of lavender for perineal healing is not.³ There are no criteria for assessing the results of trials (what does 'weakly positive' mean?). Statistically significant differences between groups are claimed where no intergroup analyses were conducted⁴ or where no differences were found⁵ or where there was no difference between groups for one outcome and no analysis for another.⁶ The authors claim that because the studies 'had no common denominator in terms of end-point' meta-analysis could not be conducted, even though suitable techniques are available: the standardised mean difference, for example, is a standard option on Cochrane Collaboration software.

Cooke and Ernst can also be criticised for drawing conclusions that go beyond the data. On the crucial question of the duration of effects they state that 'reduction in symptoms scores and anxiety were transient'. Yet no study included long-term follow-up: Cooke and Ernst claim 'no effect' on the basis of 'no data'.

Systematic reviewers need to ensure that they conduct reviews of the very highest

quality before they criticise authors of primary research.

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Counsellors in general practice

We would like to respond to the comments made by Green (September *Journal*)¹ about our controlled trial of counselling in general practice.² To take her points in turn:

- Although she may believe that Rogerian counselling was not designed for brief interventions for depression, that is its most common usage in this country. The average number of sessions received by patients that are referred for counselling in English general practice is close to six.³ Our pragmatic trial was designed to test counselling under the usual general practice conditions — that is, brief. Although our trial showed no overall advantage for counselling, in a post hoc analysis we demonstrated that severely depressed patients were *more* likely to respond to brief counselling.² Furthermore, employing a counsellor in the practice was cost neutral because patients who received it were less likely to be referred out of the practice.
- We were interested to see that Green integrates several approaches into her brief work with clients in general practice. She uses no less than five forms of psychotherapy in addition to Rogerian techniques. Although we understand that this is sometimes the

case for counsellors in primary care, we are concerned that few counsellors will have had appropriate training in each and every technique they consider themselves equipped to use. It is a brave therapist indeed who can claim to be proficient in the methods of six independent schools of psychotherapy.

- Patients in both arms of our trial improved considerably over the nine months of follow-up. It is possible that GPs in our trial may have worked with their patients more intensively than usual, given that they were aware they were being compared with counsellors. Nevertheless, our results indicate that GPs are effective communicators and counsellors. Patients with this degree of psychological disability rarely recover to such an extent without some intervention.⁴
- We are not sure how Green 'knows' that the GPs who employ counsellors are convinced that they are clinically effective. We welcome her conviction that counselling as a profession is beginning the task of validating itself empirically. Our data contribute to that exercise. Only by conducting randomised controlled trials can we promote effective treatments and eliminate ineffective or damaging ones.

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Correction

We regret the misspelling of the name of Mark A Wetherell, co-author of the letter to the Editor entitled 'Does excessive antibiotic use increase minor health complaints?' (September *Journal*, page 754-755). We apologise to Dr Wetherell for any confusion this may have caused.