

LETTERS

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New Contract, new dilemmas

I must take issue with David Tovey's assertion that 'the removal of unimmunised children from medical lists [was] a smear on our professionalism'.¹ What is actually a smear on our professionalism is that the need to even consider such a course of action should ever arise. As Vernon quite rightly observes: 'In a free society it has proved necessary to allow for conscientious objection and to accept less than 100% coverage'.² However, GPs face not insignificant personal financial loss if, despite their most committed and professional endeavours, more than an arbitrary percentage of parents on their practice list exercise their democratic right not to have their children vaccinated.

This invidious arrangement is perpetuated in the proposed new GMS contract. With no attempt at justification, Paragraph 2.11 concludes: 'Exception reporting including informed dissent will not apply'.³ No explanation is given as to why this particular marker of quality care is to be treated uniquely.

On an entirely unrelated subject, Tovey's description (in the same letter) of Brian Keighley as 'pompous' is a classic case of the pot calling the kettle black. How else could you describe Tovey's own column in the Back Pages,⁴ but as precisely the kind of turgid sermonising that gets the *BJGP* a bad name?

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References

1. Tovey D. GP pay — time to face facts. [Letter] *Br J Gen Pract* 2003; **53**: 406-407.
2. Vernon JG. Immunisation policy: from compliance to concordance? *Br J Gen Pract* 2003; **53**: 399-404.
3. *New GMS Contract: Investing in Quality*. BMA/NHS Confederation, 2003.
4. Tovey D. Tabloids. *Br J Gen Pract* 2003; **53**: 423.

Do patients want copies of referral letters?

As we all aware, the NHS Plan indicates that 'letters between clinicians about an individual patient's care will be copied to the patient as a right'.¹ This has been interpreted to mean that all letters will be copied to patients at a cost estimated to be over £6 million. A Department of Health Working Group is actively looking at the issues surrounding this initiative and will produce guidelines on its implementation.²

In my small rural practice of 2200 patients with two partners and an elderly population, we have been offering our patients a copy of their referral letter for over a year. As part of an ongoing research project we have looked at the data for the past six months where each patient is asked if they wished to receive a copy of their referral letter. Colleagues may be interested to learn that of the 107 referrals, only 22 accepted the offer of a copy of their letter and the other 85 declined. We are now researching the factors influencing our patients' decisions.

If this pattern of only one-fifth of

patients desiring a copy of their referral letter is replicated across the country, it would significantly influence the plans that many general practices and primary care organisations are implementing and make their viability questionable.

We feel that GP colleagues should be made aware of this data and that the outcomes of further research should be considered before implementing this policy nationwide.

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References

1. Department of Health. *The NHS Plan. A plan for investment. A plan for reform*. London: The Stationery Office, 2000: paragraph 10.3.
2. URL: www.doh.gov.uk/patientletters/index.htm

John Lawson — an appreciation

It was very enjoyable to read an appreciation of John Lawson in the May issue of the *BJGP*.¹ It is not just morbid curiosity (and I suspect that I am not alone) that leads me to enjoy obituaries in the national newspapers and the *BMJ*. It is more that one can learn from the achievements and dedication of predecessors who have done so much to advance our discipline and/or reach prominence in whatever walk of life.

I was disappointed however, not to read a mention of John Lawson's contribution to the 'What Sort of Doctor' initiative. He was Chairman of the first working party in 1980-1981 to look at

assessment of quality of care in general practice, followed by the second working party 1982–1984, which led to the publication of the Report of General Practice No. 23.² This document had enormous influence, which can be tracked through to the establishment of Fellowship by Assessment, the College's premium quality assurance system.

The Central Manchester Trainers Group set up a peer review system of visiting each other's practices modelled on 'What Sort of Doctor' and led by Bernard Marks in 1985, and this evolved into our system of quality assuring training environments in use today. The Faculty also developed an early system of Fellowship by Assessment. The Faculty Board decided that no doctor should be nominated for fellowship without having been visited in practice. At that time the true reason for assessment was disguised, as nominations for fellowship were without the candidate's knowledge. Although the north west system based on 'What Sort of Doctor' did not translate into the national system, I believe that the 'What Sort of Doctor' visit I received from Bernard Marks and John Frankland in April 1986 may have been the first assessment within our College leading to Fellowship.¹

I believe that general practice has only been able to produce general practitioners fit for purpose in one year of general practice-based training because of the very high quality of the training environment. The pioneers of quality assessment, led by John Lawson, are owed a debt by most graduates of vocational training since the mid-1980s, and their patients.

I look forward to learning more from appreciations of some of the giants of the early days of modern general practice and the College in the future.

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Reference

- McCormick J. John Lawson — an appreciation. *Br J Gen Pract* 2003; **53**: 422.
- Royal College of General Practitioners. *Fellowship by Assessment*. [Occasional Paper 50.] Second edition. London: RCGP, 1995.

The consequences of parallel importing

We are becoming increasingly concerned about the potential risks posed by parallel imports¹ on patient care, through the use of confusing packaging and difficulties with unfamiliar products for healthcare professionals.

A typical example in our experience has been that of a patient who was prescribed felodipine MR, with the dose titrated to a maximum of 10 mg as part of anti-hypertensive treatment. On reviewing the medication it was found that Cabren [felodipine MR 10 mg] had been dispensed from the community pharmacist, but the patient had also continued to take Preslow [felodipine MR 5 mg] that was initially dispensed, a total of 15 mg. Both of these products have been produced as a result of the pharmaceutical industry marketing practices, despite UK patent protection on Plendil. The distributors of Cabren have obtained a licence from the UK manufacturers in an attempt to undercut the parallel importers by offering discounts on the drug tariff to community pharmacists.

Other problems that have been identified with parallel imports have included the confusing use of the country of origin's foreign language on the drug packaging, information inserts, and days of the week on blister strips.² Although wholesale parallel importers have tried to address these issues by repackaging, we recommend that community pharmacists who use such parallel imports should dispense these medicines in unmarked white packaging, which would make the generic product name on the dispensing label readily identifiable to the patient. Felodipine is available under several other international proprietary names. The *British National Formulary* will have to consider listing all European Union-manufactured medicines [as it does already with existing UK generic house products], so that UK doctors are aware of parallel imports.

When a prescription is written generically, a community pharmacist may supply any brand. The European Court of Justice has ruled that a medicine patented in any European Union country can be supplied under the Free Movement of Goods.³ Such parallel

imports have been the subject of much litigation,⁴ between the multinational pharmaceutical manufacturers who wish to protect their revenues in markets of affluent countries with generously funded healthcare services, and the Association of Pharmaceutical Importers, whose members procure cheaper versions of UK-patented drugs from abroad. There remains much uncertainty in these matters, but parallel imports are likely to continue. They account for 15% of medicines dispensed, and up to 80% for some individual products. The government even expect parallel imports to be used, as community pharmacy remuneration is calculated based on these survey figures.⁵

With the impending enlargement of the European Union with east European nations, we suggest that the current situation may become more problematic for patients and prescribers. Pharmaceutical wholesalers in the new member countries will have the opportunity to generate cash exports by dramatically undercutting the existing UK-patented drugs, without having to comply with the exacting regulatory standards of UK-sourced medicines.

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References

- Types of licence/certificate: Parallel imports (PLPIs): Medicines Control Agency. www.mca.gov.uk/ourwork/licensingmeds/types/parallel.htm (accessed 1 May 2003).
- Reynolds MA. Parallel imports: vulnerable elderly. *Pharm J* 2001; **266**: 784-787.
- Taylor D. Patently confused. *BMJ* 1997; **314**: 1296.
- Bourke U. Luxembourg: medicine at the European court of justice. *Lancet* 2000; **356**: 1514-1516.
- Anonymous. Pharmacists could have to repay discount clawback on non-existent Pls. *Pharm J* 2002; **268**: 453-457.

Infection in Hong Kong

Hong Kong has a history since 1841 that is, at first, similar to that of any developing subtropical country — terrible epidemics, such as bubonic plague, on top of the constant debilitating effects of malaria, tuberculosis, and water-borne infections.

Between May and August 1894, bubonic plague raged in an overcrowded slum area, causing up to 109 deaths per day. In 15 weeks 2679 people were infected, of whom 2552 died: a mortality rate of 95%. The plague bacillus was identified that year in Hong Kong by Alexandre Yersin, a Swiss, sent from the Pasteur Institute. The colony was not clear of the infection until 1924, by which time 20 000 had died.

Smallpox killed hundreds in 1887–1888 but has disappeared following a careful vaccination programme, the vaccine being prepared in Hong Kong. Other major killers have also been eradicated — yellow fever in 1945, diphtheria in 1983, poliomyelitis in 1983. Malaria has virtually disappeared except for some imported cases.

There have been setbacks in health brought on by the Japanese occupation from 1941 to 1945, the subsequent flood of returning inhabitants after the war, and the further mass migration in 1949–1950 when the Communists came to power in China, and the most recent flood of migrants from Vietnam in the 1960s. Despite these setbacks, the decline in infectious and parasitic disease, and the rise in non-communicable disease have resulted in the latter being the more common cause of death since 1971.

The Avian Flu of 1999 was the epidemic that wasn't. Only two people died, but a million chickens were slaughtered. It was realised that the virus, which usually only affects birds, was shown to be mutating into a virus that could spread from human to human. This heroic act temporarily devastated the chicken industry in Hong Kong and across the border in China, but was praised by the World Health Organization as an act that had aborted what might have been an influenza pandemic.

Since the first case of coronavirus pneumonia was reported in March 2003 there have been 1689 cases and 225 deaths. The Hong Kong Department of Health has shown a fierce determination to control the spread of the disease, which appears to have peaked in April. Laboratories in Hong Kong were among the first to identify the virus, complete gene sequencing, and prepare appropriate diagnostic tests.

Hong Kong is fortunate in having a well-organised, well-financed and skilled public health system. It will not be long before this present epidemic will have been controlled, as others have in the past. Waiting in the wings are other potential epidemics. Last year for the first time there was a minor outbreak of dengue fever, a mosquito-borne disease that has been flying along the coast of China from the south. A prompt campaign of mosquito eradication has been effective in halting the spread.

Being a travel hub for this part of the world, constant vigilance will always be required to control the many infections brought into Hong Kong. One important lesson that has been learned from this coronavirus pneumonia epidemic is that open sharing of public health information, particularly between neighbouring countries, is essential to the health of all.

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References

1. Topical Health Report No.2. *Statistics on Infectious Diseases in Hong Kong 1946–2001*. Department of Health, Government of Hong Kong Special Administrative Region. The People's Republic of China, 2002.
2. Patterson EH. *A Hospital For Hong Kong: the centenary history of the Alice Ho Miu Nethersole Hospital*. Hong Kong: Alice Ho Miu Nethersole Hospital, 1987.
3. Mattock K. *Hong Kong Practice: Drs Anderson and Partners — the first hundred years*. Hong Kong: Drs Anderson and Partners, 1984.

Diagnosis of pneumonia

We recognise Hopstaken *et al's* significant attempt to add to the important and under-researched area of diagnosis in primary care. Most symptoms and signs traditionally associated with

pneumonia were not predictive, while the presence of diarrhoea appears to be so.¹ By emphasising the importance of 'rule in' symptoms, such as diarrhoea and raised C-reactive protein (CRP), they have played down the importance of absence of clinical signs in helping to 'rule out' more serious illness. Previous research in this area has emphasised the importance of the absence of vital and chest sign abnormalities in substantially reducing the likelihood of pneumonia.² Hospital-based prognostic models use vital and chest sign abnormalities to identify patients at lower risk for death.³ The explanation might lie in the tight inclusion criteria in Hopstaken *et al's* study, which resulted in 80% of participants having auscultatory abnormalities and all of them requiring a prior diagnosis of lower respiratory tract infection based on the GPs' clinical impression. This finding contrasts with a similar study published in the *BJGP*, in which 25% of patients recruited had abnormal auscultatory findings.⁴ We feel that the exclusion of lower risk patients might have meant that the discriminatory power of vital and chest sign abnormalities might have been diluted.

Pneumonia is a disease that can be defined clinically, radiologically, and pathologically. The authors compared a clinical definition to a radiological outcome. A 'positive' chest X-ray may not be so helpful in community settings; only a small proportion (less than 10%) of patients have abnormal chest X-ray findings and half of these people have been shown to recover without receiving antibiotics.⁵ Furthermore, the effect of a three-day delay between clinical assessment and chest X-ray, particularly in the 80% of patients who had been given antibiotics, is uncertain. An alternative 'gold standard' might have been to use duration of illness or re-consultation as a marker of severity.⁴

Studies that relate key symptoms, signs, and biochemical tests to a good or bad prognosis can inform clinical decision making. The added value of performing a near-patient test such as CRP warrants further study, but should be evaluated in the context of a clinical prediction rule based on symptoms and signs alone that seeks to 'rule out' pneumonia.

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References

1. Hopstaken RM, Muris JW, Knottnerus JA, *et al.* Contributions of symptoms, signs, erythrocyte sedimentation rate, and C-reactive protein to a diagnosis of pneumonia in acute lower respiratory tract infection. *Br J Gen Pract* 2003; **53**: 358-364.
2. Metlay J, Kapoor W, Fine M. Does this patient have community-acquired pneumonia? *JAMA* 1997; **278**: 1440-1445.
3. Fine M, Auble T, Yealy D, *et al.* A prediction rule to identify low-risk patients with community-acquired pneumonia. *N Engl J Med* 1997; **336**: 243-250.
4. Holmes W, MacFarlane JT, Macfarlane R, Hubbard R. Symptoms, signs, and prescribing for acute lower respiratory tract illness. *Br J Gen Pract* 2001; **51**: 177-181.
5. Macfarlane J, Holmes W, Gard P, *et al.* Prospective study of the incidence, aetiology and outcome of adult lower respiratory tract illness in the community. *Thorax* 2001; **56**: 109-114.

In their article on diagnosis of pneumonia in general practice, Hopstaken *et al*¹ suggest a collection of symptoms as being significant that seem to me to be counterintuitive. Until now, a patient with a dry cough, fever, and some chest pains and diarrhoea plus no abnormalities on auscultation, would have been told by me that they probably had 'flu and given appropriate advice. The patient with cough, dirty purulent phlegm, and who had definite chest signs, would have been confidently told that they had a chest infection and given antibiotics. It would seem I am wrong on both counts. I suspect many other GPs would think the same. The article almost suggests that a good history and a CRP means that we can dispense with our stethoscopes!

But before we jump on our high horses and sing a rousing chorus of 'Lies, damn lies and statistics', one

should pause and think of the possibilities, if this evidence is sound. It implies that pharmacists and nurses should — with a high degree of accuracy, if they stick to the questions and get a CRP — define who needs an antibiotic. Potentially, all those with coughs could be safely and effectively screened before seeing a GP, thus decreasing workload dramatically. This is a liberating thought — much as young ladies of yesteryear were burning their bras, young doctors today could burn their stethoscopes!

However, I wonder if the inclusion criteria were over-complex, and maybe were not what I would use as pivotal cues, when compared with normal GP diagnostic methods. I must also confess to getting lost on the statistics!

It seems a trial well worth replicating.

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Reference

1. Hopstaken RM, Muris JWM, Knottnerus JA, *et al.* Contribution of symptoms, signs, erythrocyte sedimentation rate, and C-reactive protein to a diagnosis of pneumonia in acute lower respiratory tract infection. *Br J Gen Pract* 2003; **53**: 358-364.

Opening Pandora's box

Pringle, in his editorial on 'Re-evaluating revalidation and appraisal', has finally dared to open the Pandora's box on the link between the two processes.¹ His point that appraisal was never designed to be a summative assessment tool for the high stakes assessment process of revalidation (where doctor's jobs and livelihoods are on the line) should not be ignored and swept aside.

In April, I wrote to Dr Ian Bogle, Chairman of Council of the BMA, pointing out the very same point as Pringle had made. He replied that though the recommended route to revalidation would be five satisfactory appraisals, the GMC had provided another route to revalidation, namely the 'independent route'. This was open to all, but at the time of writing this letter, no details as to the criteria

required to fulfil this route to revalidation was available.

The implication of this recommendation is that the BMA and GMC are prepared for doctors to spend time, money (both theirs and the tax payers) and effort on a process that has no sound basis behind it and would not protect patients. The logic behind linking the two being that it would at least be relatively convenient, in that there would be no duplication of work. In his reply to me, only those who '... feel uneasy about the two processes being closely associated with one another... and have deep concerns ...' should take it upon themselves to undergo revalidation via the independent route. Any doctor prepared to act on their conscience and take the independent route would most likely face more work, and spend more time and money. They would still have to undergo appraisal as this would be compulsory too. How many overworked GPs are going to be willing to do this?

There is nothing wrong with appraisal or revalidation, but there is something wrong with linking the two. In revalidation, doctors are asked to demonstrate that they are fit to practise, but ironically, under current recommendations, they are being to ask to do so via a system that is not fit for the purpose. If we do not act now then we will not only be letting ourselves down, but also our patients.

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Reference

1. Pringle M. Re-evaluating revalidation and appraisal. *Br J Gen Pract* 2003; **53**: 437-438.

Breach of confidentiality?

Professor Fahey and his colleagues address a serious issue in their article 'Sudden death in an adult taking methadone.' But the case report uses two initial letters to refer to the patient. I am concerned at the use of the patient's actual initials as an identifier

and whether this could lead to a breach of confidentiality.

There is plenty of information about this patient in the article. Enough to allow easy discovery of his full name and tragic history. It took me less than five minutes to identify him on the Internet.

It could be argued that this patient's details were already in the public domain, but should a professional journal publish details that allow any patient to be identified? The case report guidelines on your website state: 'It is essential to obtain permission from any patients whose story is to be used as the basis for a case report (see http://jama.ama-assn.org/info/auinst_req.html#separate for full requirements of informed consent) and to maintain patient confidentiality.'

Those guidelines would appear to be breached by this report. Was there any reason why this patient could not have been referred to simply as 'X'?

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1. Fahey T, Law F, Cottee H, Astley P. Sudden death in an adult taking methadone: lessons for general practice. *Br J Gen Pract* 2003; **53**: 471-472.

Editor's note

We should share the blame for this lapse, and are grateful to Eamonn Clarke for pointing it out. A reminder to be more vigilant in future.

Definition of diabetes mellitus

The discussion paper by Rothenbacher *et al*¹ in the May 2003 issue of the *BJGP* raises several issues, ranging from a definition of diabetes mellitus that is inconsistent with the recommendation of the World Health Organization to misinterpretation of their results.

In 1999, the World Health Organization reported a change in the diagnostic criteria of diabetes mellitus.² The British Diabetic

Association recommends the adoption of the following new criteria for diagnosing diabetes mellitus³:

Diabetes symptoms plus:

- (a) a random venous plasma glucose concentration equal to or higher than 11.1 mmol/l; or
- (b) a fasting plasma glucose concentration equal to or higher than 7.0 mmol/l; or
- (c) two-hour plasma glucose concentration equal to or higher than 11.1 mmol/l two hours after an oral glucose tolerance test.

In asymptomatic patients the diagnosis should be confirmed by at least one additional venous glucose test. Further information is available on the website of the British Diabetic Association: www.diabetes.org.uk

The authors did not report the type of blood sample when determining glucose. I noticed that many health-care professionals in Germany use capillary blood glucose measurements for diagnosing diabetes mellitus. The British Diabetic Association recommends that the diagnosis should be confirmed by using a venous plasma sample.³

The discussion paper is based on an incomplete and imprecise definition for diagnosing diabetes mellitus. This may lead to under-recording of the true situation, false reassurance, and management delay. The validity of their brief report is questionable.

Table 1 showed the results of the different variables associated with a high HbA_{1c}. This table is misleading because the different characteristics of a specified variable do not add up to the total number of participants (845). For example, smoking history was documented in 750 patients. Ninety-five participants were not taken into account, leading to distortion of their results.

Table 1 also showed that 261 patients were managed by diet only and 236 patients were diagnosed as diabetic one to four years previously. It seems that many patients have been on a prolonged diet therapy, despite the inability to achieve good metabolic glycaemic control. Correction of the metabolic derangement can prevent and delay the progression of diabetic

complications and many studies showed the benefits of oral hypoglycaemic agents or insulin. The United Kingdom Prospective Diabetes Study confirmed that intensive glycaemic control over a ten-year period in 3867 newly diagnosed type 2 patients with either sulphonylureas or insulin decreased the risk of microvascular diabetic complications.⁴

Table 1 does not consider other important variables associated with a high HbA_{1c}, such as hyperlipidaemia. Hyperlipidaemia is commonly seen in diabetic patients and optimising diabetic control often improves an abnormal lipoprotein in patients with type 1 diabetes, and sometimes those with type 2 diabetes.⁵

Almost one-third (31.7%) of the so-called younger patient group (aged 40 to 59 years) had elevated HbA_{1c} of 8% or higher.

The compliance variable in Table 1 as assessed by the doctor can be biased to blame the patient, rather than to look at other factors, such as education and possibly the need to intensify the therapy. Table 1 showed that a good diabetic control was also not achieved in a significant number of patients receiving diabetic medication.

The authors reported the need to improve diabetic care. On the other hand, they did not specify the strategy to achieve this goal. Audit is essential, and the audit cycle, if performed correctly, can improve the care of diabetic patients.

References

1. Rothenbacher D, Rueter G, Saam S, Brenner H. Younger patients with type 2 diabetes need better glycaemic control: results of a community-based study describing factors associated with a high HbA_{1c} value. *Br J Gen Pract* 2003; **53**: 389-391.
2. Alberti KGMM, Zimmet PZ. *Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications*. Report of a WHO Consultation. Part 1: Diagnosis and Classification of Diabetes Mellitus. Geneva: World Health Organization, 1999.
3. British Diabetic Association. *New Diagnostic Criteria for Diabetes*. May 2000. URL: www.diabetes.org.uk
4. United Kingdom Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). *Lancet* 1998; **352**: 837.
5. Watkins PJ. ABC of diabetes: Cardiovascular disease, hypertension,

and lipids. *BMJ* 2003; **326**: 874-876.

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Recruitment strategies for research

We read about Davey *et al*'s¹ difficulties with recruitment with considerable interest. Their conclusion was that 'it may be more practical in future to recruit directly through local newspaper advertisements.'

The evidence that they present does not appear to support this conclusion. First, the newspaper article they used, in a paper with a circulation of 82 000, produced only 112 eligible subjects, of whom 66 were recruited. In the practices, contacting 10 584 people produced 262 eligible subjects. It is unlikely that they could have met their recruitment target of 302 subjects using the newspaper article alone.

Secondly, this method of recruitment is likely to produce a biased sample of the population, limiting the external validity of the study. The authors note that the subjects recruited using the newspaper article were significantly more likely to be female than those recruited through the general practices. Potentially important factors, such as socioeconomic status and education level, were not reported. While this study is randomised, given the nature of the intervention it would be difficult to blind participants. Attitudes to the allocated treatment could affect the response seen, and these attitudes might differ between the different recruitment groups.

The problems the authors encountered in using practice registers are not insurmountable. A similar study in Nottingham randomised 786 subjects from two general practices, having contacted 9296 patients aged over 45 years in a postal survey.² We are recruiting participants with musculoskeletal disorders from practices in the Medical Research Council General Practice Research Framework using similar techniques. In one such study,³ a research officer (SP) visited practices to facilitate practice nurses in search-

ing practice computers for a defined age range, and printing patient details onto preprinted invitation letters and study registers. The process was simplified by writing 'macros' for the more complex procedures. We used window envelopes, so there was no need to print address labels. For another study,⁴ which has disease and age entry criteria, we have written local MIQUEST⁵ queries that practices with compatible computer systems can use to identify potential participants. The nurses then use a custom-designed program to produce letters and study registers. This approach avoids the need for external researchers or practice nurses directly accessing patient records.

Notwithstanding the problems Davey *et al* encountered, general practice lists⁶ are more productive and less prone to bias than a newspaper advertisement. Much can be done to reduce the time and effort involved.

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References

1. Davey R, Matthes Edwards S, Cochrane T. Recruitment strategies for a clinical trial of community-based water therapy for osteoarthritis. *Br J Gen Pract* 2003; **53**: 315-317.
2. Thomas KS, Muir KR, Doherty M, *et al*. Home-based exercise programme for knee pain and knee osteoarthritis: randomised controlled trial. *BMJ* 2002; **365**: 752-756
3. URL: <http://www.smd.qmul.ac.uk/gp/mpcc/bexs.htm>
4. URL: <http://www.smd.qmul.ac.uk/gp/mpcc/toib.htm> ISRCTN79353052
5. URL: <http://www.nhsia.nhs.uk/miquest/pages/default.asp>

6. Walsh K. Evaluation of the use of general practice age-sex registers in epidemiological research. *Br J Gen Pract* 1994; **44**: 118-122.

Homelessness and primary care

I would agree with the conclusions of Riley *et al* that current policy needs to target resources in areas such as primary care, to address the health needs of homeless people.¹ The problem remains how to maximise the health gain from limited resources targeted at homeless populations. Riley *et al* mention specialised general practices for homeless people. The ideal model of best practice is that such specialised centres register homeless people in crisis and then help to move them on into mainstream general practice.² I would contend that, in the context of limited resources, such a model will remain the worst apart from all the rest! One of the limitations of this model is the risk of homeless people becoming strongly attached to the specialised homeless practice and having difficulty moving into mainstream primary care. It is my view that this is as much a problem with clinician attachment to homeless patients as it is a reluctance of homeless people themselves to move into mainstream primary care. This is an area that requires further research. I would suggest that such specialised practices would also benefit from future resources being targeted at employing general practice liaison workers who can help re-house vulnerable homeless people and help integrate them into a mainstream general practice. This could require going with the homeless person to the first few visits with the new GP, helping with setting boundaries and helping the homeless person to manage the conflicting emotions resulting from such a change. I would contend that receptionists working in the specialised general practice could take on such liaison work as an extension to their role. As gatekeepers of the specialised practice they are often much less likely than the clinicians to have difficulty in disengaging from involvement with homeless people when the time is right.

And, finally, let us not delude ourselves that a strong economy will lead to less of a problem with meeting the health needs of homeless people. For all of the limitations that our NHS has in providing quality health care to homeless people, the superpower of the United States of America still envy such provision!³

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References

1. Riley AJ, Harding G, Underwood MR, Carter YH. Homelessness: a problem for primary care? *Br J Gen Pract* 2003; **53**: 473-479.
2. Lester H, Wright N, Heath I. Developments in provision of primary health care for homeless people. *Br J Gen Pract* 2002; **52**: 91-99.
3. Frey J. Homelessness: a primary care response. [Book review]. *Br J Gen Pract* 2002; **52**: 698.

Special non-clinical interests as career development

I totally agree with Amanda Howe and Mike Pringle's editorial 'Special non-clinical interests — GPs in education, research, and management'.¹

Involvement in teaching and in management can raise standards of care. Therefore, protected non-contact time within the working week is needed to establish clearly defined roles, responsibilities, and terms of service. Teaching, research, and management have to be relevant career options, whose status and conditions deserve proper consideration and equal payment for workforce planning and skill utilisation. This is important to help guard against the burnout and frustration often visible in GPs who are more involved in these activities, and also to fulfil the New Definition of General Practice and General Practitioners, as set out by WONCA following drafting work by EURACT Council.^{2,3}

Also, Roger Jones wrote about seeing a much bolder attempt to endorse the 'mixed portfolio' approach to general practice, in which patient care is combined with other non-clinical activities.⁴

I also think that it could be introduced as a 'wedge-shaped' commitment, with substantial work in early years tapering to a considerably reduced working commitment for more senior doctors.⁵ This would be an excellent opportunity to reinvent general practice as an attractive career with a progressive structure.

Career development and prevention of burn-out in general practice/family medicine are dependent on a variety of factors, but the two pre-eminent issues are:

1. *Professional satisfaction in the primary role.* This is largely determined by: recognised training and qualification that largely excludes poorly trained and/or incompetent practitioners; recognition of general practice/family medicine as a specialist discipline; availability of professional peer-driven continuing education; and adequate remuneration and lifestyle, comparable with specialist colleagues. There are unlikely to be many alternative career options at all for GPs/family physicians until the first three of the above criteria have been met.
2. *Availability of alternative career options within the discipline, with commitments in non-clinical interests.* Recognised training and qualification generates an academic body of general practice/family medicine. The academic body must then attain recognition and parity with other disciplines; for example, in the appointment of professors. Only then will career options become available.

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References

1. Howe A, Baker M, Field S, Pringle M. Special non-clinical interests — GPs in education, research, and management. *Br J Gen Pract* 2003; **53**: 438-440.
2. Carelli F. New GP Contract and European definition. [Letter.] *Br J Gen Pract* 2003; **53**: 61.
3. Richards TD. New GP Contract and European definition. *Br J Gen Pract* 2003; **53**: 155-156.
4. Jones R. The new contract — worth

voting for? *Br J Gen Pract* 2002; **52**: 602-603.

5. Carelli F. New Contract and career development. [Letter.] *Br J Gen Pract* 2002; **52**: 765.

Primary care is cost-effective care

The report¹ that strictly controlled pharmacological treatment of opiate misuse in primary care is effective calls into question the whole subspecialty of 'addiction psychiatry' (a subspecialty that, although dealing with drug and alcohol problems, has had little noticeable impact on the most common addiction — nicotine). Since a large number of services structured to permit consultant psychiatric supervision of nurses and others in provision of, supposedly essential, 'psychosocial support' will be threatened by the prospect of these findings being transferred elsewhere, the Sheffield group should prepare for a political backlash from vested interests. Nevertheless, the non-drug costs of the scheme described appear to be under £350 per patient per year, based on costs of £60 000 per year per working time equivalent GP, £30 000 per year per nurse specialist, and £40 000 per year for management and administration (in other words, less than £1 per day per patient) while services led by consultant psychiatrists have higher unit costs in the region of £4 per day per patient, based on a psychiatrist (£60 000) supervising, say, six nurse specialists with case loads of 40 patients each and similar administrative support.

The outcomes reported by Keen *et al* after one year are comparable to those found in the National Treatment Outcome Research Study.² It follows that commissioners of services should review the provision of service in areas where there is a waiting list (or time!) for treatment of opiate misusers in consultant-led services against outcomes, to ensure that the extra cost of psychosocial support is associated with appropriately enhanced outcomes.

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References

1. Keen J, Oliver P, Rowse G, Mathers N. Does methadone maintenance treatment based on the new national guidelines work in a primary care setting? *Br J Gen Pract* 2003; **53**: 461-467.
2. Gossop M, Marsden J, Stewart D. *NTORS at one year*. National Treatment and Outcomes Research Study. Department of Health, November 1998.

SARS revisited

Harndon and Mayon-White provide us with an excellent synopsis of the ongoing SARS outbreak and include brief guidance to primary care management.¹ Readers should be aware of the excellent PHLS website <http://www.phls.co.uk/>, which provides updated guidance on this and many other infectious conditions to the GP's desktop computer. The primary care guidelines on management of SARS in the community detail how to respond to low and high-risk suspect cases. Harndon alludes to the resource implications of the current guidance and, indeed, if the disease becomes more prevalent, then current policy will need review.

The policy of home visiting, daily phone contact and two blood samples for suspect cases managed at home will provide considerable workload for practices with more than one suspect case. Contacts of low-risk possible cases have no restrictions placed upon them but close contacts of high-risk possible cases (contact with known or probable case from an affected area, or contacts of a known or probable UK SARS case where that case has been in close contact with a known SARS case in an affected area) are dealt with differently. In this instance voluntary home isolation for ten days is suggested. If medical contacts are also to be isolated, then a rapid depletion of available staff will inevitably occur unless some other arrangements for assessment and follow-up other than by the primary health care team are put in place.

On 4 June the advice for protection of health care workers in contact with suspect SARS cases was updated. Surgical masks are only regarded as sufficient for use by cases to prevent

spread in transit, but attending medical staff should use a higher grade respirator (conforming to at least EN149:2001 FFP2 or the NIOSH-approved N95). This change in advice has not been widely publicised.

The description of life within the SARS epidemic makes stark reading.² Medical practice when dealing with the febrile patient has already changed, perhaps irreversibly, in Hong Kong. Is enough being done now to prevent a similar outbreak in the UK? Already we have seen one febrile patient in surgery following a trip to Hong Kong; the history, only elicited during the consultation, was that the patient had waited in a crowded waiting room. Has the public and the profession got the message? Have you got a supply of appropriate masks in your on-call bag?

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References

1. Harndon A, Mayon-White R. Severe acute respiratory syndrome — novel virus, recurring theme. *Br J Gen Pract* 2003; **53**: 434-435.
2. Lyon DJ. A view from inside the SARS epidemic. *Br J Gen Pract* 2003; **53**: 508-509.

The future of academic primary care

Professor John Frey's editorial in the March issue of the *BJGP* on the future of academic primary care¹ drew comparisons between what is happening in North America and the situation in the UK as described in the second MacKenzie Report, *New Century, New Challenges*.²

However, neither Professor Frey nor the second MacKenzie Report emphasised the fundamental structural difference between academic departments of primary care in North America and in this country. Academic departments in North America were originally established to run family medicine residencies, with teaching medical students a secondary consideration. In contrast, the university departments of general practice in this country were set up for

undergraduate teaching, and have only recently become involved in postgraduate training.

The reasons for this are both historical and political. In the 1950s and 1960s, it was easier to establish vocational training on the education budget in North America and therefore base it in university departments, whereas in the UK it was easier to fund postgraduate training on the Health Service budget, with a quite separate organisation to university departments.³ These came later, following the Todd Report on Medical Education in 1968.⁴ The result was small university departments with no critical mass and little formal contact with postgraduate advisers and course organisers.

This situation is changing and the second MacKenzie Report found that 97% of departments now had formal links with postgraduate general practice education, with joint appointments in over one-third of cases. However, there are still only two academic units where undergraduate teaching and postgraduate training are combined into one centre or institute, namely Dundee and Sheffield. This academic split between undergraduate teaching and postgraduate training is unique in clinical disciplines, and has much to do with the lack of a career structure for academic general practice.

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References

1. Frey JJ. A murky future for academic primary care. *Br J Gen Pract* 2003; **53**: 179-180.
2. Society of Academic Primary Care. *New Century, New Challenges*. London: Royal College of General Practitioners, September 2002.
3. Hannay DR. Undergraduate and postgraduate medical education: bridging the divide. *Br J Gen Pract* 1994; **44**: 487-488.
4. Royal Commission on Medical Education. [Report.] London: HMSO, 1968.