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Authors' response

Like a previously published Cochrane review,[1] our synthesis of the international literature on community maintenance for treating opiate dependence[2] supports the effectiveness of methadone and buprenorphine in reducing illicit opiate use and promoting retention in treatment. Our study adds to the Cochrane review by focusing on how effectiveness is influenced by the setting in which maintenance treatment is delivered, by the intensity of treatment, and by the provision of additional medical and psychosocial services.

To date, research primarily relates to patients receiving maintenance treatment in outpatient clinics. Recently, community maintenance has been extended to general practice in a number of countries including Australia and France.[3] Although high-quality evidence is sparse, our review suggests that treatment with methadone or buprenorphine in general practice could be effective in patients who meet criteria of sufficient clinical stability and when provided by primary care physicians who have appropriate training. However, in an era of evidence-based medicine, there is a need for randomised controlled trials that properly evaluate community maintenance of opiate dependence in general practice. This is particularly true for conditions such as drug misuse, in which pharmacological treatment is only one component of effective therapy.

Our review has highlighted the daily doses at which methadone and buprenorphine are effective. Trials have suggested that the minimum effective daily maintenance dose may be 50 mg for methadone and 8–16 mg for buprenorphine. Higher doses of methadone and buprenorphine appear to be more effective at enhancing treatment retention and reducing illicit opiate use. Higher doses of buprenorphine have been shown to attenuate heroin craving, but the evidence relating to methadone is more equivocal.[4,5]

We and other authors have noted the issue of underdosing of methadone in the UK in our review and other publications.[2,6,7] A recent survey of prescribing practices of general practitioners in Scotland revealed that only 58% of GPs used methadone doses in the recommended range.[6] We believe that underdosing of methadone in the UK has been recognised for some time now, but that the difficulty lies in how to change clinical practice. UK guidelines need to clearly reinforce the message that higher doses of methadone are more effective. As guidelines alone are unlikely to change clinical practice, various strategies to disseminate and implement guidelines need to be explored.

Steven Simoens
Chair in Pharmacoeconomics
Centre for Drug and Patient Information, Katholieke Universiteit Leuven, Belgium
E-mail: steven.simoens@pharm.kuleuven.ac.be

Catriona Matheson
Senior Research Fellow
Christine Bond
Professor of Primary Care
Karen Inkster
Research Fellow
Anne Ludbrook
Senior Research Fellow

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MeReC Bulletin

The *MeReC Bulletin*[1] arrived (Benzodiazepines and and newer hypnotics) and automatically I took down my sackcloth and prepared myself for an evening of penance and self-mortification (what else does a GP do now there is no 'out of hours?').

There, as expected, in the summary was the comment about inappropriate prescribing — GPs behaving badly again!

But as I was collecting the ashes from the grate I wondered when I last prescribed inappropriately. How often do we as GPs hand out benzodiazepines on a whim, without dire warnings of addiction, tolerance and side effects? How often when signing repeat prescriptions for the elderly on sleeping tablets do we make a QALY-fied decision to continue? 'I balanced all, brought all to mind, … In balance with this life, this death'.[2] Are patients stupid? Do they take these drugs thoughtlessly or do they crave the extra hour of sleep and escape from the realities they find themselves in? In the consulting room, benzodiazepines are a drug of desperation — of the patient for relief and of the GP to help that person to have some sort of tolerable existence.

Could we do better — obviously. But are we inappropriate — no. Information handed down from august bodies seems to lack connection with reality. Pharmacokinetically they are correct. However benzodiazepines are only prescribed psychosocially.

This lack of connection is also shown in the advice about co-proxamol. The intention seems pure — reduce avoidable deaths — no-one would argue with that. But how sensible is the thinking behind it? The MHRA consulted openly about co-proxamol[3] — as many as three patients had the temerity to reply — although I suspect that patient views are irrelevant in this situation. The MHRA advise the use of paracetamol as first line[4] with the addition of ibuprofen. Both are standard drugs of proven worth. Paracetamol is regarded as effective, but a recent *Bandolier* article[5] finds that, for osteoarthritis, there is no evidence that paracetamol is better than placebo. It is well know that NSAIDs cause

renal damage and hypertension, not to mention approximately 2500 deaths per year in the UK[6] — in the US NSAIDs caused more deaths than asthma and melanoma put together. *Bandolier* comments, 'when you are in a hole, stop digging'.[5] It maybe that those patients are not stupid — the desire to have co-proxamol is based on *n*-of-1 trials that they have tried for themselves, and many are sure that this is a better analgesic than others. The logic of banning co-proxamol is probably less than that of banning NSAIDs, and may relate more to the politics that surround Dr David Kelly's suicide and the lack of pharmaceutical company pressure than anything else.

Prescribing in almost all areas is driven psychosocially — whether it is for benzodiazepines, pain relief, chemotherapy or for hypertension. Bodies that advise GPs need to provide substantial discussion on these aspects, or expect their advice to continue to be ineffectual.

Chris Gunstone
General Practitioner, Burton upon Trent
E-mail: gunstone@talk21.com

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Assessing general practice

It was good to see so much useful debate in the June issue of the Journal around the area of general practice assessment. Wass provides a balanced and thoughtful editorial stressing the importance of underpinning change with clear research evidence.[1] She points to the potential threats posed by the pace of change and also by the risk of politically driven agendas. The future of the MRCGP is discussed with the suggestion that will face 'radical change'.

It appears inevitable that part of this change will see a change in emphasis towards workplace assessment and Swanick and Chana[2] provide a comprehensive review of the issues surrounding this. They persuasively argue for the benefits of local assessment but point out concerns that exist around reliability. It is hard to disagree with their suggestion that dealing with this will require the professionalisation of GP teachers. It is important that all stakeholders should realise that the cost and complexity of this task is not to be underestimated.

Simpson and Ballard's[3] paper on the oral examination for the MRCGP demonstrates that even experienced examiners, undergoing regular development and appraisal, cannot always be relied upon to test the competencies being assessed. This problem is likely to be even more acute for GP trainers, many of whom will have received little or no training in assessment methodology. This can be addressed given adequate education, time and remuneration, but it is not clear that all trainers will welcome an increasing role in assessment. One fear has to be that political pragmatism will result in a botched compromise, with the collection of competencies being exactly the sort of reductionist box-ticking exercise that Wass warns against.

Jewell[4] provides a timely reminder that 'Modern general practice implies expertise in areas beyond purely medical competence'. He particularly points to the importance of shared decision-making skills and the ability of GPs to practice within a defensible ethical framework. For all its faults, the present MRCGP has not shied from addressing these higher competencies. It can be argued in fact that the exam has been responsible for positive, measurable change in performance in these areas.

It is inevitable that the exam will change in response to the drive for workplace assessment, but it is essential that new assessment methods can be shown to have clear advantages over those already in use. There is a fairly large baby that risks being thrown out with the bathwater.

Roger Tisi

GP Principal, Essex
Course Organiser, Southend VTS
Member of Panel of Examiners RCGP
E-mail: roger@tisi.fsnet.co.uk

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Dirty magazines

Authors' response

I thank Dr Jenkinson, for his expressed interest in the study.[1] Most of the magazines he refers to are naturally not common reading in Norway. However, we have our equivalent titles. The data set of 15 magazines is really too small to begin to look for differences. The thought is an interesting and relevant one though. Table 1 in our study shows that most of the magazines gave similar numbers of colonies (range = 4–115; average 22) and only one or two were clearly dirtier than the others.[2] If I remember correctly, the worst offender was a magazine for boat owners (showing water doesn't always wash clean).

Colin Charnock
Faculty of Health Sciences, Oslo University College
Norway. E-mail: colin.charnock@hf.hio.no

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