be supplemented with the confident use of clinical judgement.

Peter Brindle
GP and Wellcome training fellow in health services research,
Department of Social Medicine,
University of Bristol, Canynge Hall,
Whiteladies Road,
Bristol BS8 2PR.
E-mail: peter.brindle@bristol.ac.uk

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Limited resources?

The editorial by Ryan and Watson[1] begins, 'In publicly provided healthcare systems, when limited resources are coupled with unlimited demand, decisions have to be made about the efficient allocation of scarce resources.' If a supermarket manager wrote an editorial claiming that demand for food is infinite and it is therefore impossible to keep his shelves stocked, we would wonder how he kept his job. So why do we take seriously the claim that medical services, which, unlike food, most people tend to avoid as much as possible, are subject to 'unlimited demand'?

Nobody would deny that some new medical procedures are costly and that their availability can involve difficult decision-making. Most people would also agree that such decision-making should be transparent and evidence-based. But the best efforts of NICE and others cannot compensate for the fact that there is, in the NHS, no effective mechanism for measuring demand and ensuring that it is met. This is not because demand is unreasonable, let alone infinite: it is simply because there is no mechanism for matching demand with supply.

So we need to do more than try to make resource allocation transparent and evidence-based. We also need to see that it is followed by the money to pay for it. The present system of funding the NHS from general taxation is admirable in principle but fails because no politician is willing to argue the case for greater taxation. If, on the other hand, there were a ring-fenced ('hypothecated') health tax, then there would be a mechanism for the public to be properly involved in debate about resource allocation, and to come up with the money to pay for what they really want.

Richard Lehman
GP, Hightown Surgery, Hightown Gardens,
Banbury OX16 9DB
Richard.lehman@gp-k84059.nhs.uk

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Research governance: major barrier to medical student research

For her special study module on sexual health and research, a second year medical student (RY) decided to do a questionnaire survey of access to sexual health care among attenders aged <25 years in the waiting room at a genitourinary medicine (GUM) clinic. The time allotted for the special study module was 1 day per week for 10 weeks. Her protocol, patient information sheet and questionnaire (available from the authors) were seen by the chairman of a local research ethics committee and deemed to be borderline audit/research.

The brief, anonymous questionnaire was not particularly intrusive. It asked about age, sex, ethnicity, employment, ease of finding the GUM clinic, whether they preferred coming there to seeing their GP, and two questions on knowledge of sexually transmitted infections. The patient information sheet made it quite clear that there was no obligation to complete the questionnaire and that this would not affect treatment.

The GUM physician at the clinic (at a hospital outside London) was supportive and the findings might have been useful. However he referred the proposal to the research governance manager. This was fatal. She wrote:

> '… It would not be possible to expect a student project to be approved in the time constraint you have indicated ... It is likely that an Honorary Contract will be required for this study. In order for such a contract to be issued, a Criminal Records Bureau Check will be undertaken. CRB checks are currently taking approximately 6 weeks. If the study is also involving vulnerable groups, it is likely that an Occupational Health Check will also be required. Both these checks would be conducted by the relevant Human Resources department.
>
> In my view this is research and not audit. There are no apparent standards set with which to compare. The proposed research question is dealing with a very sensitive subject on potentially vulnerable individuals. There would be serious concerns with regard to the data access, especially as the researcher does not appear to have access to this information in the course of their work at this clinic.
>
> The research question and questionnaire have the potential of creating situations for the participants that the researcher may be unable to deal with, therefore involving other departments without their prior knowledge. Safeguards for both the researcher and research population must be in place — access to further counselling etc as a basic minimum.
>
> Please do not hesitate to contact me

if I can be of any further assistance.' (!!!)

Need I say more?

Pippa Oakeshott
Reader in General Practice,
Community Health Sciences,
St George's, University of London
E-mail: oakeshot@sgul.ac.uk

Rashmi Yadava
Second year medical student.

Who is the journal for?

A GP with no academic credentials might be unwise to criticise apparently minor slips in the *BJGP*, and might himself be deemed 'not good enough' by that board. However, your declared editorial wish to attract and publish criticism may prompt others with quixotic and obsessional personalities to write to you, providing material for research on the serious disorder of dissent from the common view. Can the Journal be taken seriously when Edzard Ernst's interesting paper is entitled 'Complimentary Medicine' on the Journal's outer cover, and a similar mistake is repeated in 'The Back Pages'? On page 24 I read that a patient is suffering from 'blood cancer', an expression perhaps for those lay people who have not heard of leukaemia or red cell equivalents, but not really for a medical journal.

Jennifer Marsden's clear writing retains an Americanism, 'practice', whereas current style in the UK might suggest the spelling 'practise' when used as a verb. British contributors to the *New England Journal* accept editorial conversion of their words to American norms. Do other readers find, 'How this fits in' printed as a blue highlight irritating? Why imitate the *British Medical Journal*? Does the Editorial Board believe that readers of the *BJGP* have reading difficulties, or are many papers not understandable? The first letter in the January *BJGP* criticises sponsorship, yet the next announces the author's success in winning an award sponsored by a private health scheme and contains the possible grammatical solecism, 'clinical indications makes light work …'. A cynical mentor told me that the quality of a medical journal was inversely related to the quality of the paper on which it was printed. Is that why my weekly copy of the *New England Journal* is often exciting to read, whereas the monthly *BJGP* is not? Who is the *BJGP* written for? Sometimes it seems to be published for the referees. Could too many referees provide no editorial coherence? The extreme view, 'Peer review, as at present constituted, encourages lying and favours the corrupt', provocatively put by Horrobin[1] almost 10 years ago, would not even reach the sub editor's desk in the present day. To mix the words of Leo Rosten's fictional character, Hyman Kaplan, and those of *Private Eye* some 60 years later, 'Some mistakes netcheral — I think we should be told'.

Michael G Bamber
GP, Colsterworth Medical Practice,
The Surgery, Back Lane, Colsterworth,
Grantham, Lincs NG33 5NJ
E-mail: mgbamber@nhs.net

Competing interest
A New Year's resolution to be less critical and more constructive.

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1. Horrobin DF. Peer review of grant applications: a harbinger for mediocrity in clinical research? *Lancet* 1996; **348**: 1293–1295.

Spelling

May I be one of the first to COMPLEMENT you this festive season on the titling of your article on COMPLIMENTARY medicine[1] (sic) — You really must stop paying your type-setters (or whatever they're called in the computer age) in peanuts, you know. However, very glad to read Edzard Ernst's destructive comments on silly Smallwood.

Tony Cole
E-mail: tony@colescott.co.uk

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1. Ernst E. The 'Smallwood report': method or madness? *Br J Gen Pract* 2006; **56:** 64–65.

Nurse and pharmacist prescribing

Brian Keighley's[1] excellent article on nurse/pharmacist prescribing points out the possible dangers. There are some absurdities too.

The GMC proposes prohibiting retired doctors from writing a prescription. So retired consultant physicians will no longer be allowed to prescribe.

However, the government proposes that he will be able to get one by asking a nurse to prescribe it for him.

Ivor E Doney
3 Wallcroft,
Durham Par,
Bristol BS6 6XJ

REFERENCE
1. Keighley B Should nurses prescribe? *Br J Gen Pract* 2006; **56**: 68.

GP or not to be?

As my A-levels loom ahead and I prepare to narrow my science choices down to chemistry and biology, my wish to become a GP seems to dwindle as I hear my parents discussing how their job is becoming decreasingly centred on actually practising medicine. It appears that the computerisation of the consultation, relinquishing of the doctor's role to others in the team and the many hoop jumping, target-reaching hours are now part and parcel of a generalist's work. I realise that doctors being checked is in the interest of the patient's health and safety, and certainly as a patient I'd be happier knowing my GP was unlikely to make fatal mistakes. I also realise that it's not just primary care