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

Need I say more?

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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'.

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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
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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.

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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

doctors who have hoop jumping to face. Currently I have to hoop jump to access the top marks of various GCSE coursework assignments. For example, in physics I have to state my findings 'in the simplest way possible,' before I can go back and describe it all again in greater detail. (Why not just explain in detail in the first place?)

I'd be willing to accept the devolution of the GP role if it meant practising would entail less responsibility; however it seems practitioners must now bear the brunt of nurses', pharmacists' and a host of other people's medical mistakes. So is it worth the 2 years of A levels, many years of medical school and then the good old MRCGP for a job with less medicine and more responsibility? (Or perhaps the late-home, tired-parent views aren't representative!)

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Telephone reviews of chronic illnesses

We write in response to the news that national arbiters for the GP contract are to rule on whether telephone reviews for patients with asthma count towards Quality and Outcome Framework targets.[1] Not to allow this would be a major setback to those who are developing and implementing innovative service provision models, which aim to increase access and offer choice of routine care to patients with long-term illnesses. The decision by West Wiltshire, and Kennet and North Wiltshire Primary Care Trusts, not to allow telephone-based asthma reviews, may be charitably described as unnecessarily restrictive in their interpretation of the contract; although cynics may speculate that this is a cost-saving exercise in the aftermath of practices' unexpected 'over performance' in achieving quality targets.

Patients with long-term diseases do not have equal opportunities of access to care. As clinicians, we fix times and locations of interactions with patients that are strongly biased in our favour. Ministers have expressed concern about this and are calling for longer opening hours. Providing the choice of remote reviews for chronic disease is a more practical solution which, if used appropriately,[2] can provide care that is effective, cost-effective and valued by patients.[3] It is a perverse ruling that encourages practices to 'exception report' those patients unable or unwilling to attend face-to-face reviews, rather than encouraging clinicians to offer convenient remote consultations.

Studies have demonstrated improved access, in the context of asthma reviews in primary care,[4–6] and we have strong theoretical grounds for believing that this benefit is also likely to be true for a range of other chronic disorders. Furthermore, the telephone is only one of a growing array of communication channels (email, SMS text messaging, etc) now available that can facilitate delivery of convenient and accessible care. A 'ban' on telephone consulting would be a retrograde step that could impact negatively on the use of these other communication modalities.

It is ultimately patients who will be the losers if the decision to disallow telephone consultations is upheld. Telephone reviews are now acknowledged by the British Thoracic Society/Scottish Intercollegiate Guideline Network asthma guidelines;[7] they should similarly be embraced by the Quality and Outcomes Framework.

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Imaging in sinusitis

We write to inform you of the results of our recent audit relating to imaging in cases of suspected chronic sinusitis.

All facial X-ray requests over a 6-month period at Hope Hospital, Salford, were audited. We found that 54 plain X-rays were performed in cases of suspected sinusitis. Of these, 34 were reported as normal, 16 were abnormal and four were unavailable for review. Forty patients were subsequently referred for further ENT review. We found no correlation between X-ray findings, incidence of referral and eventual treatment. Of 54 plain X-ray requests, 50 originated from primary care (either family GP or emergency hospital GP), three requests were from Accident and Emergency and one was from a non-ENT outpatient clinic.

Examination of the current guidelines and evidence regarding appropriate imaging in suspected sinusitis suggests that this current practice is now outdated. Guidelines from the Royal College of Radiologists discourage the use of plain facial X-rays in suspected cases of sinusitis. Plain X-rays have been shown to have low sensitivity and specificity for sinusitis and expose