Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them via email to **jhowlett@rcgp.org.uk**, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

Re: The treatment of acute infectious conjunctivitis with fusidic acid

In reply to the letter of DM Fleming, dated 13 December 2005, in which he raises the issue of selection bias, we would like to point out that the randomisation prevented selection bias, although some residual bias (or confounding) cannot be precluded in small trials such as ours. That, for example, was the reason why we adjusted for a slight, but important imbalance in the age distributions between the groups.[1]

We reported an adjusted number needed to treat (NNT) of 18.97 (95% CI: NNT [harm] = 8.92 to infinity to NNT [benefit] 5.47). This number is based on the weighted average of subgroup-specific NNTs within our trial. We reported a single NNT under the assumption that the clinically relevant subgroups in our trial have NNTs that are similar to the overall one. Of course, one may question this assumption as Dr Fleming appears to do. Thus, the important issue Dr Fleming raises is that of generalisability of trial results or effect modification. There is a large body of literature on this topic.[2–4] Briefly, the question is whether clinically relevant subgroups of patients may be distinguished to which (very) different NNT apply? There are several options to explore this question. First, one may perform (biology-informed) subgroup analyses within a trial. An obvious subgroup analysis, based on the culture results, we performed ourselves. However, too many subgroup analyses are bound to yield false-positive results.[5–7] Second, one may perform new trials in homogeneous subgroups of particular interest, in allergic patients for example. Third, one may try to tackle the problem in meta-analyses using meta-regression, but individual patient data meta-analysis is the preferred design.[8]

In conclusion, the rigorous design and execution is likely to guarantee the internal validity of our findings. Speculations on effects that deviate from the overall mean findings are always possible and cannot be rejected straightaway. For example, we agree that our trial may have underestimated the effect of fusidic acid if many patients with a red eye based on an allergy only were included, assuming that is in such patients fusidic acid has no beneficial effect. We have no data to assess this hypothesis. However, in a modestly-sized trial such as ours the options to explore subgroup effects are extremely limited. We should welcome new well-designed and rigorously executed trials in this field.

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The future of general practice

Several contributors to the February edition of *BJGP* offer views about the future of general practice in particular and, by implication, the NHS as a whole.

Like climate heating, the evidence is all about us that change is occurring and that it is likely to be inimical to all concerned. Despite the black propaganda of some in government, there has never been a reluctance to countenance appropriate change on the part of GPs. To the contrary we have experienced perpetual revolution for decades now and kept our heads above water, even when the changes we have embraced have been self-evidently gross errors of policy emerging from heedless dogmatists.

If we are sincere in our belief that we can do better, perhaps we should enter the political arena formally. Dr Richard Taylor has been elected twice to parliament on a 'health service' ticket, so we would be following precedent.

A healthcare professional standing in every constituency at the next election would be an interesting challenge to the conventional parties, none of whom, as far as one can gather, have much to offer the NHS — a subject that has an immediate and powerful meaning for almost all electors.

Who knows? We might win and, being unencumbered by conventional political constraints, we could accomplish much besides effectively modernising the NHS and placing it outside the immediate ambit of future political interference.

I'm game. Anyone else?

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