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.

The fairy godmother has spoken

Our Editor, in his comment on the White Paper 'Our health, our care, our say'[1] rightly points out that 'the difficulty of provision for disadvantaged groups is a stain on the face of primary care.' He later says that the proposition that life checks for all, as proposed in this government White Paper, are likely to be of marginal value.[2] This might be true of the articulate worried well. However, some disadvantaged groups are very likely to benefit considerably from structured relevant health checks, for example, people with severe learning disabilities.[3]

As far a people with learning disabilities are concerned, a previous government White Paper (2001)[4] promised Health Action Plans (HAPs), for all patients with learning disabilities, by June 2005. A sample of 451 practice managers responded to a questionnaire about the Valuing People targets in November 2005. This suggested that 'the targets for the White Paper have not been met, and in particular most practices seem unaware that they exist … 76.7% of practices overall did not know how many of their LD [learning disability] patients had been offered a HAP'. Health checks are necessary to inform HAPs. Nearly 67% of practices said they could identify their patients with learning disabilities and 36.4% said they offered health checks, mostly annually' (personal communication, 2005). With regard to people with learning disabilities this new White Paper says that the Department of Health 'has previously committed to introduce regular comprehensive health checks for learning disabled people … We will review the best way to deliver on this earlier commitment.' (page 100)[1] As David Jewell says of the new White Paper, 'It is government as fairy godmother … No doubt we should all like to go to the ball, but … who is going to pay?'[1]

Those with learning disabilities often, like Cinderella,[5] remain as our submerged silent minority patients. While reviewing the best way to deliver, why not get on with delivery now? If a third of practices are already providing some form of health check service to their patients there should be plenty of experience on which to draw.

What is needed is cash rather than further procrastinating reviews. Why not ensure fulfiling 100% of current targets now, which if done properly, will involve appropriately structured health checks? GPs, in working with their patients, carers and nurses, should be well able to deliver. What is needed is government putting money where its mouth is. Fairy godmother has spoken again, this time she must also wave her wand.

Graham Martin
Red Roofs, Warwickshire, CV11 5TW
E-mail: graham@ghbmartin.co.uk

Jill Rasmussen
The Moat House, Surrey, RH1 3PN

REFERENCES

1. Department of Health. *Our health, our care, our say: a new direction for community services. Health and social care working together in partnership.* London: TSO, 2006. http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf (accessed 10 Apr 2006).
2. Jewell D. Fairy godmother has spoken [editorial]. *Br J Gen Pract* **56;** 2006: 163–164.
3. Baxter H, LoweK, Houston H, *et al.* Previously unidentified morbidity in patients with intellectual disability. *Br J Gen Pract* 2006; **56:** 93–98.
4. Valuing people: a new strategy for learning disability for the 21st Century. Cm 5086. London: DH, 2001. http://www.archive.official-documents.co.uk/document/cm50/5086/5086.htm (accessed 10 Apr 2006).
5. Martin G. Valuing people: a new strategy for learning disability for the 21st century: how may it impinge on primary care?[editorial] *Br J Gen Pract* 2001; **51:** 788–790.

Discovering the research priorities of people with diabetes in a multicultural community

The paper by Brown *et al*[1] is a much needed piece of research in an area that has been neglected by funding bodies in the past.[1] However, despite its patient-centredness, it is still not truly ethnocentric — as far as readers could tell, the ethnicity of the 'Asian' focus groups was not clarified. As there are big differences between 'Asian' or 'South Asian' communities[2] (usually defined as people originating from the Indian sub-continent), either of which should be defined in a paper, it is currently considered more culturally sensitive to identify groups by their own specified ethinicity.[3,4] It would not alter the word count to use, say, 'Pakistani' instead of 'Asian' and is far more specific.

For me, this is a lesser issue than that of how we deal with the findings — for the last 25 years, black and minority ethnic communities complain that they are extensively researched, their needs are defined,[5] but that nothing comes back to improve their situations. The current situation is still one of short-term funding for black and minority ethnic community projects, both research and service provision, with add-on monies to mainstream planning (for example, the Health Inequalities Fund of the Welsh Assembly Government initially offered 3 years' funding, then increased it by 2 more years and finally by 1 more year, but each time towards the end of the previously agreed funding period).[6] In addition, research and academic

institutions continue to have a major interest in molecular biology and laboratory-based research, so it is likely that the disparity between what patients say they want and what research produces, will continue.

Kamila Hawthorne
Department of General Practice, Cardiff University
E-mail: HawthorneK@cardiff.ac.uk

REFERENCES

1. Brown K, Dyas J, Chahal P, *et al*. Discovering the research priorities of people with diabetes in a multicultural community. *Br J Gen Pract* 2006; **56:** 206–213.
2. Johnson MRD, Owen D, Blackburn C, Nazroo J. *Black and minority ethnic groups in England: the second health and lifestyle survey*. London: Health Education Authority, 2000.
3. Kaplan JB, Bennett T. Use of race and ethnicity in biomedical publication. *JAMA* 2003; **289(20):** 2709–2716.
4. McKenzie KJ, Crowcroft NS. Race, ethnicity, culture and science [editorial]. *BMJ* 1994; **309:** 286–287.
5. Webb P. Ethnic health project 1979/1980. *R Soc Health J* 1982; **102(1):** 29–34.
6. Welsh Assembly Government. Health Inequalities Fund. http://www.cmo.wales.gov.uk/content/work/inequalities-in-health-fund/index-e.htm (accessed 10 Apr 2006).

Low breastfeeding rates and milk insufficiency

Muirhead *et al* have conducted a study which has shown that peer support does not increase breastfeeding rates.[1]

The Department of Health recommends exclusive breastfeeding for the first 6 months of life.[2] In Muirhead's study, the median duration of breastfeeding (in primigravidae) was only 7 days. This is so far short of Department of Health recommendations that we suggest thought should be given to pursuing an alternative approach.

The reason most frequently given by mothers for discontinuation of breastfeeding is milk insufficiency.[3] It is clear therefore that advice to mothers should ensure the prevention (and if necessary treatment) of milk insufficiency.

Weight gain is likely to be the easiest practical way to assess milk sufficiency; weighing babies has been shown not to reduce breastfeeding rates (in fact, it may improve them).[4]

We suggest that interventions to increase breastfeeding rates should be targeted at the prevention (and if necessary treatment) of milk insufficiency, and milk production should be confirmed by regular weighing.

CA Walshaw
JM Owens
Oakworth Surgery, West Yorkshire, BD22 7HN
E-mail: anne.walshaw@bradford.nhs.uk

REFERENCES

1. Muirhead PE, Butcher G, Rankin J, Munley A. The effect of a programme of organised and supervised peer support on the initiation and duration of breastfeeding. *Br J Gen Pract* 2006; **56:** 191–197.
2. Department of Health. Breastfeeding. http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4084370&chk=WFMaW7 (accessed 10 Apr 2006).
3. Hamlin B Brooker S, Oleinikova K, Wands S. *Infant feeding 2000*. London: The Stationery Office, 2002.
4. McKie A. Young D. MacDonald P D. Does monitoring newborn weight discourage breast feeding? *Arch Dis Child* 2006; **91:** 4–46.

Business management in general practice should feature in the nMRCGP

Having completed my registrar training in September 2005, an area that I believe needs to feature clearly in the nMRCGP is business management related to general practice.

The existing examination comprehensively addresses knowledge base (MCQ); the ability to integrate and apply theoretical knowledge and professional values (written paper); decision making (oral); and the assessment of consulting skills (video). Having completed the MRCGP, I feel the exam has provided me with greater skills and confidence in many aspects of my life as a GP.

However, the existing exam does not focus enough on business management within general practice. Arguably, the oral component could explore this, but in my experience did not. During my registrar training, I learned a limited amount about business aspects through attending practice meetings, the occasional tutorial and reading through the weekly rags.

What I feel would be invaluable to all registrars would be to incorporate business management in the nMRCGP. This may take the form of an OSCE or viva station exploring common business dilemmas within the clinical skills assessment (CSA) component or integrated into the workplace based assessment (WPBA).

Making GP registrars more aware of business aspects within general practice will make them better prepared as they begin life as a GP, particularly with the evolving nature of the new contract and the underlying political forces that continually shape the future of general practice.

Cyrus Fernandes
Bansons Lane Surgery, Ongar, Essex CM5 9AR
E-mail: cyrusfernandes@yahoo.com

Up-to-date findings show change in acute otitis media consultation trend

We write in reference to the paper by Williamson *et al*,[1] which reported that total consultations for acute otitis media (AOM) have fallen between 1991 and 2001.

We conducted a similar study using the most up-to-date General Practice Research Database. Data were extracted for all AOM consultations for 0–18 year olds between 1 January 1991 and 31 December 2005.

We found a similar decline in paediatric AOM consultations between 1991 and 2001 (177.3 to 80.5 per 1000 person-years). However, with the inclusion of more recent data (2002–2005), we can see that the trend for the incidence of paediatric AOM consultations has actually stabilised since the year 2000.

This change in the incidence of AOM consultations may now suggest that the