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## Entering general practice

Congratulations on publishing Daniel Furmedge's telling short paper.<sup>1</sup> Full marks for his insight and interpretation. He reminded me of my first Claire Wand Fund Prize on 'Postgraduate education for the newly qualified doctor in preparation for entry into general practice.'

That was more than half a century ago. Returning from my 6-year sabbatical in the Army, I was seriously worried that none of my clinical teachers had any personal experience of general practice, and that no mention of the subject was made.

The stigma was real, enormously encouraged by the arrogance of Lord Moran, who had publicly declared that the GP was 'the doctor who had fallen off the ladder of success.'

On one point I disagree with Daniel Furmedge. The GP is essentially a generalist — not a specialist. The specialist is the one who has chosen to wear Lord Moran's blinkers.

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## Osteoarthritis

We read with interest the recent 'Top tips in 2 minutes: Osteoarthritis of the knee',

which was published in the May issue of the *BJGP*.<sup>1</sup> Although written in an engaging style it is baffling that such an article should appear just 2 months after the published NICE osteoarthritis guidelines and yet contain no reference to them.

While certain pieces of advice contained in the article are consistent with the NICE osteoarthritis guidelines (notably 'don't leave surgery too late'), it also substantially diverges in many places:

- Core treatment is information and advice about the condition; weight loss; exercise (both aerobic and strengthening have been shown to be effective — there is no basis for the emphasis on 'non-impact').
- Glucosamine is not recommended for use within the NHS. While 1500 mg glucosamine sulphate has demonstrated a small benefit over placebo for knee osteoarthritis guidelines, this product does not currently have an EU licence.
- Topical NSAIDs are recommended.
- Neither viscosupplementation nor debridement are recommended ('when symptoms worse than X-ray' is relatively meaningless).
- X-rays not recommended to confirm a clinical diagnosis of knee osteoarthritis guidelines; indicated only in the presence of giving way/locking.
- MRI not currently recommended for diagnosis, even in early osteoarthritis guidelines.

We would encourage readers of *BJGP* seeking Top Tips in 2 minutes on this subject should consult the NICE osteoarthritis guidelines 2-page summary and the accompanying version for members of the public.

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*Top Tips in 2 Minutes for the May issue was compiled in January 2008, a month before the NICE guidelines were published. A correction was published in the June issue with reference to the latest NICE guidance. DOI: 10.3399/bjgp08X302907.*

## Tooke report

Professor Field commented on the Tooke report in the April Journal.<sup>1</sup> He suggests it is good news for general practice because it emphasises excellence and recommends an extension of GP training to 5 years.

Am I the only GP who qualified in the late seventies or early eighties who is slightly bemused by this?

We were trained by the age old 'rote-regurgitation' system (learn by rote, regurgitate in exams). Most of us attended half-day release in our post-graduate years — only if ward work allowed (quite right too!). There was often little or no departmental teaching. By modern educational standards a poor system.

So why do we need 5 years of training? It must be because we are not good doctors, patients do not value the service we give, and we have not coped with change.

Yet, we are the generation who learnt maths on slide rules (I still have mine!). We have seen massive changes in the practice of medicine, in general practice, including the arrival of practice nurses, computers, contract changes, clinics, and the devolving of clinical work from hospital to general practice. We still have the respect

of the general public.

The European Working Time Directive has reduced doctors' hours — yet we are reliably informed that the excessive hours of yesteryear were very detrimental to our health and provided poor quality learning environments — so I guess we learnt little from those experiences. The modern system should be better as the doctors are wide awake and enthusiastic, rather than drained, stressed, and exhausted as we were.

Am I the only doctor who thinks that general practice is maybe a bit easier? Since we qualified the BNF has been introduced in its present excellent form, there are amazing numbers of experts who tell us what to do. There are mountains of guidelines and of course, QOF. Evidence-based practice has come into being, and opinion rightly takes second place to evidence. Within seconds you can get reliable information from your computer — even during a consultation. The patients present in much the same way, with much the same problems, and are often easier because they are better informed.

Modern medical education has mushroomed into ever-increasing activity. There are plethoras of diplomas and courses about teaching. So why can it not deliver in 3 years? Is there good evidence that new educational systems are that much better than the old? Is it possible that modern education actually disempowers young doctors, rather than empowering them?

When I was a course organiser and trainer, it seemed that there were some doctors who need extra time and help, the great majority who managed quite well, and a very few who should not have got as far as they did. The vast majority do not need an extra 2 years of training. Can the NHS afford it? (Especially if we factor in increased consultation times which the College is championing). Are we moving toward a system of consultant GPs — maybe with lists of 5000, with most work being done by lesser qualified individuals? Does this increasing cost of GPs herald the demise of personal doctoring, long-term relationships, and actually lead us right into Darzi polyclinic general practice?

There is a well known phrase 'the map is not the territory', to which we should maybe add 'theory is not reality'!

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## Knowledge of risk factors in cancer

Many modifiable risk factors for cancer have been reported, including: smoking, estimated to cause one-third of UK cancers;<sup>1</sup> obesity; low intake of fruit and vegetables, and physical inactivity, estimated to cause approximately 3% and 2% of cancers respectively;<sup>2</sup> excessive alcohol use, accounting for about 4% of cancers, and excess exposure to sunlight. Public knowledge of these risk factors is little known, as surveys have generally concentrated on specific cancers;<sup>3,4</sup> or been relatively small.

We performed a survey in eight general practices in Northern England. Adult patients attending in December 2007 or

January 2008 were asked to select six from 12 possible risk factors. As well as the six risk factors, we included six false ones: 1556 questionnaires were returned. The mean number of risk factors selected was 5.6. Results are shown in Table 1.

The virtue of this survey is its simplicity and its size. These are weaknesses too: in that we chose not to request details such as sex or age. However, little difference between the sexes was identified before.<sup>4</sup> In a previous survey of 1000 women enquiring about risk factors for breast cancer two-thirds identified a positive family history, yet only 14% identified age, 19% hormone replacement therapy, and 12% oral contraception.<sup>3</sup> An older survey asked about 10 true and four false causes, similar to this current survey.<sup>4</sup> Smoking results were similar, with 93% identifying a relationship between smoking and lung cancer; likewise, 42% linked a diet low in fruit and vegetables with bowel cancer. Responses for obesity were much lower, with 46% of females linking this with breast cancer, yet only 13% of males doing so: this compares with 70% identifying overweight in the current survey.

Our results suggest publicity about smoking has worked. Similarly, excess sun exposure, excess alcohol use, and being overweight are now generally recognised as risk factors. Less encouraging was the relatively low level of knowledge about diet and exercise. This suggests a new

**Table 1. Participants identifying putative cancer risk factors.**

	Participants marking this factor increases cancer (n = 1556)	
	n	%
Risk factors associated with cancer		
Smoking	1486	96
Exposure to sunlight	1288	83
Being overweight	1082	70
Excessive alcohol	1054	68
Lack of fresh fruit/veg.	654	42
Not taking regular exercise	619	40
Risk factor debatably associated with cancer		
Exposure to traffic fumes	813	52
Risk factor with little or no scientific support		
Exposure to microwaves	554	36
Lack of iron in the blood	487	31
Lack of vitamin C	405	26
Eating spicy food	142	9
Drinking very hot drinks	105	7