findings from the ECLIPSE trial should enhance our ability to help women make the best choices about their health.

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nMRCGP exam

As I am now in my ST3 year and due to complete GP training next August, I am eligible to take my Clinical Skills Assessment (CSA). But when?

Having entered GP training at ST2, I completed 6 months in general practice and 6 months in an innovative post during my ST2 year. During ST3 I have 6 months of paediatrics, followed by 6 months of general practice. And there lies my dilemma.

I could sit the CSA in October or January/February, but at that time I'll be doing paediatrics. Although useful for my general practice career, not the best preparation for the CSA, as this will test a much wider area of practice.

Option 2 is to sit the CSA in May. I'll be back in general practice by this time so will have a chance to prepare properly for the assessment. However, results aren't published until June, just 2 months before I complete my training. I would therefore be applying for jobs without having completed my nMRCGP — would I even be eligible for short-listing? And if I don't pass ... My training programme complete but no nMRCGP. With the expense and time involved in taking the CSA, I don't want to just 'give it a go' in January without feeling properly prepared.

I am aware that other deaneries schedule the whole of ST3 in general practice, allowing trainees to choose from all three sittings of the CSA. Perhaps a sitting in mid-March for those of us doing a more restrictive training programme?

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Diabetes prevention

With the publication of several large randomised controlled lifestyle change trials showing benefit in delaying or preventing progression from pre-diabetes to type 2 diabetes, work has been taking place in many locations to translate research evidence into practical interventions to improve the care of our patients at the primary care level.

Laatikainen and colleagues are to be congratulated in conducting the large Diabetes Prevention Project in Australia.[1] Like us, they successfully delivered a structured programme to patients with pre-diabetes using group work, delivering education enhanced by motivational techniques. Our programme was a randomised controlled pilot study testing two different dietary interventions.[2] Theirs recruited a larger number of pre-diabetic participants and was able to show a statistically significant effect in reducing progression to type 2 diabetes compared with baseline using an audit methodology.

The biggest obstacle faced by many working in this field, including ourselves, is to secure adequate funding to develop and refine such pragmatic intervention programmes. This work is vital to the wellbeing of our patients. Up to 90% of people who develop diabetes may not have done so had their lifestyle choices been different, and interventions have been shown to make a real difference.[3] We congratulate our Australian colleagues on their excellent work and are also envious of the opportunities that they have for substantial translational research funding.

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In response to the article entitled 'Can type 2 diabetes be prevented in UK general practice?' published in the August issue of the *BJGP*,[1] we would like to highlight our experience with diabetes prevention.

In the Finnish Diabetes Prevention Study,[2] participants who successfully achieved their lifestyle-change goals for physical activity and diet did not go on to develop diabetes after 7 years of follow-up.[3] To determine whether the results of clinical trials could be reproduced in the 'real world' of primary care, the GOAL Lifestyle Implementation Trial to prevent Type 2 diabetes in primary health care,[4] a trial using a structured programme was designed and trialled in Finland.

In 2004–2006, a sister project of GOAL was run in the Greater Green Triangle region of South Australia: the Greater Green Triangle Diabetes Prevention Programme (GGT DPP). This study evaluated the feasibility of a structured group programme for lifestyle modification in Australian primary healthcare settings

(*n* = 237). The imputed reductions in the risk of diabetes and cardiovascular disease were 40% and 18% respectively. All components of the metabolic syndrome apart from systolic blood pressure were improved. Intervention components included information provision, group discussions, self-monitoring of behaviour, goal-setting, and planning for behaviour change and maintenance. Full details of the intervention and its results have been reported elsewhere.[5]

The success of the GGT DPP in primary healthcare settings did not go unnoticed. The Department of Human Services in Victoria has already begun implementing this programme on a large scale, with the aim of having 25 000 Victorians reduce their risk of type 2 diabetes by 2011.

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APMS contracts

I read Dr Conlon's letter in your September issue[1] with some incredulity and a great feeling of sympathy for those of his employees who may have been faced with redundancy or a loss of earnings in order for the practice to avoid a financial disaster. This was, after all, an APMS contract for which he made a successful bid at a price he felt was appropriate for the services he was offering. It is absolutely vital for any practice or consortium to formulate a sound business plan in advance of any APMS contract bid to see if it is economically viable. In this case, it clearly was not. Full credit must go to the PCT, of whom I am not acknowledged to be a great admirer, for increasing the payments to 85% when there was no contractual obligation for them to do so.

I hope that this example serves as an object lesson to all those practices who may be tempted to make bids for APMS contracts without doing the most basic arithmetic. It is unfortunate that more GPs today have not had the benefit of a grounding in the Classics. If they had they would understand the meaning of the Latin expression *caveat emptor*.

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Authors' response

We wanted to trigger a debate on resource inequality in health care, so were not expecting someone to call our financial judgement into question, and use our letter to warn against APMS contracts.

First, our defence: we made careful calculations, agreed and accepted by the appointing PCT. In addition, our bid price was above the minimum recommended by the BMA at the time. In that sense, we believe that responsibility for the financial judgement is a shared matter, and directing criticism at one party unhelpful.

APMS contract setting continues to evolve, and we understand that some contracts are now approaching a fairer reflection of what is needed to provide high quality care in the local context. If this continues, then APMS may yet become an effective vehicle for redressing the inequity of resource we observed in our original letter.

That said, Dr Zuckerman makes a valid point about *caveat emptor*. Our experience shows the real risks that a single practice faces when bidding for an APMS contract. By comparison, large commercial organisations can probably write off the loss of an underfunded contract for several years, so as to get their foot in the door.

This, however, creates a dilemma: for existing practices to sit on their hands while commercial organisations harvest large swathes of primary care, or to seek to preserve the qualities of continuity and professionalism that characterise general practice by exposing themselves to risk. Judging the effects on health inequalities of action versus inaction is difficult. The logical alternative — for large groups of independent practices to form partnerships to increase their clout — still seems too unappealing for most GPs to follow it through.

No one held a gun to our heads, but our sense of threat to general practice was and remains strong. We chose to act by applying for this contract. Despite the financial challenge, the practice team remains positive. The majority of our patients are being treated by experienced GP principals, not locums or salaried doctors on short-term contracts. Had we been over-inhibited by *caveat emptor* this situation could be very different.