physicians and regulatory bodies can play a vital role in achieving this goal. It is now time to stop promises and to start practices in order to achieve the premium health status that will be beneficial for all.

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DOI: 10.3399/bjgp10X502182

Incapacity certification

I was delighted to read the April Focus in the *BJGP.*[1] The new more positive approach to certification of incapacity is to be welcomed. Starting in 1947, whenever I issued a 'certificate' I gave an expected duration of incapacity. This enabled both patient and employer to anticipate 'return to full function'. It also led the patient to realise that they had a duty to 'get better'. My patients always knew I was not a soft touch for extended sloth.

PS. I still feel strongly at 90.

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DOI: 10.3399/bjgp10X502191

Automated electronic reminders and primary prevention of cardiovascular disease

Holt *et al* present interesting data on the effect of automated electronic prompts on primary prevention of cardiovascular disease.[1]

Their results support recent anecdotal observations I made while trying to achieve the yearly cardiovascular disease (CVD)/cornary heart disease (CHD) QOF targets for one of the local practices in Fulham.

It is interesting to see these observations corroborated by a well conducted randomised controlled trial.

In contrast to the EMIS software used in their study, our practice uses VISION software that has a built in CVD/CHD risk calculator based on the Framingham risk equation applied to the most recent risk factor measurements.

Each patient's CVD/CHD risk is immediately visible in the lower left-hand corner of the computer screen. Clicking on the reported risk score releases a pop-up window containing the risk calculator and recent measurements of risk factors such as smoking, cholesterol, and blood pressure, presenting the opportunity to address unmet QOF targets and control clinical parameters.

Translating identified risk and appropriate interventions into improved clinical outcomes is the bigger challenge, and one clear potential implication from Holt *et al*'s study is that high QOF CVD/CHD scores may not necessarily result in reduction in cardiovascular event rates.

The reasons for this are not clear and are probably multifactorial, however, poor patient understanding of CVD/CHD risk and risk reduction is contributory and can be partly addressed by using the CVD/CHD risk calculator interactively during consultations.

This can be done by demonstrating to the patient how his or her risk can increase or decrease with positive or negative changes in the measurements of clinical parameters. Therefore, the CVD/CHD risk calculator can also be a powerful tool used to build therapeutic relationships and improve understanding of CVD/CHD risk and what it means for each patient on a personal level.

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DOI: 10.3399/bjgp10X502209

Near-patient testing holds most promise for acute conditions

We welcome the editorial by Professor Khunti on near-patient testing in general practice.[1] He states that quality assurance is of utmost importance if near-patient testing is to be successfully implemented in general practice. We fully agree on this