

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.

Fahad Saleem,

Universiti Sains Malaysia, Pharmaceutical Sciences, Jalan Sungai Dua, Penang, 11800, Malaysia. E-mail: fahaduob@gmail.com

Jalan Sungai Dua,

Universiti Sains Malaysia, Pharmaceutical Sciences, Penang, Malaysia.

Azmi Ahmad Hassali,

Universiti Sains Malaysia, Pharmaceutical Sciences, Penang, Malaysia.

Asrul Akmal Shafie,

Universiti Sains Malaysia, Pharmaceutical Sciences, Penang, Malaysia.

REFERENCES

1. Kannel WB. Blood pressure as a cardiovascular risk factor. *J Am Med Assoc* 1996; **275**(20): 1571–1576.
2. Kearney PM, Whelton M, Reynolds K, *et al.* Global burden of hypertension: analysis of worldwide data. *Lancet* 2005; **365**(9455): 217–223.
3. Kearney P, Whelton M, Reynolds K, *et al.* Worldwide prevalence of hypertension: a systematic review. *J Hypertens* 2004; **22**(1): 11–19.
4. Sailesh M, Norm RCC. Hypertension management: time to shift gears and scale up national efforts. *Hypertension* 2009; **53**(3): 450–451.
5. Sarafidis PA, Li S, Chen SC, *et al.* Hypertension awareness, treatment, and control in chronic kidney disease. *Am J Med* 2008; **121**(4): 332–340.
6. Anonymous. 18% population suffering from hypertension. *The Daily Times*. http://www.dailytimes.com.pk/default.asp?page=story_28-3-2005_pg7_32 (accessed 11 May 2010)
7. Azhar S, Hassali MA, Ibrahim MI, *et al.* The role of pharmacists in developing countries: the current scenario in Pakistan. *Hum Res Health* 2009; **7**: 54.
8. WHO. *Health system profile*. Egypt: Regional Health System Observatory, 2006.
9. Hashmi SK, Afridi MB, Abbas K, *et al.* Factors associated with adherence to anti-hypertensive treatment in Pakistan. *PLoS One* 2007; **2**(3): e280.

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.

Roy Webb,

Green Gables, Kersey, Suffolk, IP7 6EB.

REFERENCE

1. Jones R. Challenges to advocacy in primary health care. *Br J Gen Pract* 2010; **60**(573): 234.

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)/coronary 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.

Ayokunle Abegunde,

The New Surgery, 128 Canterbury Road, Folkestone, CT19 5SR.

E-mail: Rabegs@doctors.org.uk

REFERENCE

1. Holt TA, Thorogood M, Griffiths F, *et al.* Automated electronic reminders to facilitate primary cardiovascular disease prevention: randomised controlled trial. *Br J Gen Pract* 2010; **60**(573): 251–256.

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

point. Moreover, he correctly concludes that near-patient testing has a number of potential benefits beyond patient satisfaction, although the full potential of its integration and implementation has not been exploited, while he specifically calls for rigorous evaluations to determine improvements in harder outcomes and cost-effectiveness. Yet, we noticed that he mainly focused on near-patient testing opportunities in the field of cardiovascular medicine. A recent review, not included in this editorial, showed unsatisfactory results of near-patient tests for monitoring patients with diabetes, with hyperlipidaemia, or requiring anticoagulant therapy.² But the same research group also showed that patients managed with near-patient tests had similar or superior medication adherence: that is an important finding in patients who often use multiple medications.³

The potential of near-patient testing for acute conditions in general practice is largely neglected in the editorial. Yet, in our opinion this is where near-patient testing can have the most effect. GPs preferably want to decide on management within the 10-minute-consultation for an acute condition. Recently it was shown that using a clinical decision rule combined with a point of care D-dimer reduces the need for referral to secondary care of patients with clinically suspected deep venous thrombosis (DVT) by almost 50% and is associated with a low risk for subsequent venous thromboembolic events. Point of care D-dimer tests can therefore contribute important information and guide patient management, notably in low risk DVT patients.^{4,5} A second example of a near-patient test with immediate consequences for management is the use of point of care C-reactive protein (CRP) testing in lower respiratory tract infections. A recent trial showed a dramatic decrease in antibiotic prescriptions when GPs used CRP testing to guide antibiotic management.⁶ Both biomarkers now have a solid evidence-base of their use, with multiple studies showing robustness, effectiveness on hard outcomes, and cost-effectiveness. So contrary to what Khunti claims, we

contend that there has been quite some progress in terms of rigorous evaluations of near-patient testing initiatives in primary care in the past decennium, especially when focusing at their use in acute conditions. And this is exactly where near-patient tests will benefit GPs and patients most.

Jochen WL Cals,

Post-Doctoral Researcher and GP Trainee, CAPHRI School for Public Health and Primary Care, Maastricht University, The Netherlands. E-mail: j.cals@hag.unimaas.nl

Geert-Jan Geersing,

GP and Researcher, Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht, Netherlands.

REFERENCES

1. Khunti K. Near-patient testing in primary care. *Br J Gen Pract* 2010; **60**(572): 157–158.
2. Gialamas A, St John A, Laurence CO, Bubner TK. Point-of-care testing for patients with diabetes, hyperlipidaemia or coagulation disorders in the general practice setting: a systematic review. *Fam Pract* 2010; **27**(1): 17–24.
3. Gialamas A, Yelland LN, Ryan P, *et al*. Does point-of-care testing lead to the same or better adherence to medication? A randomised controlled trial: the PoCT in General Practice Trial. *Med J Aust* 2009; **191**(9): 487–491.
4. Buller HR, Ten Cate-Hoek AJ, Hoes AW, *et al*. Safely ruling out deep venous thrombosis in primary care. *Ann Intern Med* 2009; **150**(4): 229–235.
5. Geersing GJ, Janssen KJ, Oudega R, *et al*. Excluding venous thromboembolism using point of care D-dimer tests in outpatients: a diagnostic meta-analysis. *BMJ* 2009; **339**: b2990.
6. Cals JW, Butler CC, Hopstaken RM, *et al*. Effect of point of care testing for C reactive protein and training in communication skills on antibiotic use in lower respiratory tract infections: cluster randomised trial. *BMJ* 2009; **338**: b1374.

DOI: 10.3399/bjgp10X502218

GPs and minor ailments

In recent years there have been a number of reports of GPs being troubled by patients with minor ailments, while at the same time concerns have been expressed about the iceberg of unreported illness in the community.

When the perceptions of people are taken into account, one study showed that 26% had symptoms that to them

were serious, but did not seek medical advice for. In contrast 11% had symptoms that they did not think were serious but that were referred to a GP. The iceberg of significant symptoms in the community was therefore more than twice the size of so called trivial complaints.¹

This begs the question of 'trivial to whom?' GPs are extensively trained and paid to distinguish minor ailments from those that may be more serious. It is therefore disappointing that prominent members of the profession have recently promoted the view that doctors are overwhelmed with minor ailments, with the implication that patients should seek advice elsewhere and spend more on over-the-counter medicines.

David Hannay,

Kirkdale, Carsluith, Wigtownshire, DG8 7EA. E-mail: drhannay@gmail.com

REFERENCE

1. Hannay DR. *The Symptom Iceberg*. London: Routledge & Kegan Paul Ltd., 1979.

DOI: 10.3399/bjgp10X509649

GP training 'schemes'

I would like to bring to mind an alternative viewpoint to that brought up in the May Focus regarding length of GP training 'schemes'.¹ Length of training for a GP is compared unfavourably with those elsewhere, on the basis that it involves only 3 years (2 in hospital and 1 in 'registrar' posts) compared to longer, far more defined schemes in other specialties. I am not sure that this very short standard GP training scheme is in fact the standard, and I am not sure the 'standard' differs so very much really from that in other specialties in Britain.

GP training has always been more flexible than other speciality schemes, allowing trainees far more opportunity for more mature self-evaluation, self-directed learning, and practical experience organisation. It may be possible to satisfy the requirements of the